The Journal OF THE South Carolina Medical Association

PUBLISHED EVERY MONTH UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION.

OFFICE OF PUBLICATION, 4 VANDERHORST STREET, CHARLESTON. S. C.

Application pending for entrance as second class matter at the Post Office at Charleston, S. C.

ANNUAL SUBSCRIPTION, $2.00.

Vol. I Charleston, S., C. September 21, 1905 No. 4.

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South Carolina Medical Association

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THE JOURNAL

OF THE

SOUTH CAROLINA MEDICAL ASSOCIATION.

4 Vanderhorst Street, Charleston. S. C.

ROBERT WILSON, Jr., Editor. T. P. WHALEY, Associate Editor.

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ANNUAL SUBSCRIPTION, $2.00.

THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred pages.

All matter must be in the hands of the editor by the 10th of each month.

EDITORIAL COMMENT.

A COMPARISON.

It is a commonplace remark that familiarity with danger breeds within us an indifference to perilous situations. The soldier accustomed to the carnage of battle looks unconcernedly upon scenes before which another would recoil with fear; and they that go down to the sea in ships are less mindful of the perils of the deep than they to whom such experiences are new and strange. Perhaps it is the same cause which tends to make us indifferent to the dangerous presence of so common a disease as tuberculosis, while an occasional epidemic of yellow fever creates a deep and wide-spread feeling of fear, which in some localities produces a condition akin to panic. It is true that yellow fever spreads more rapidly, kills more quickly, and causes more deaths in a short period of time than tuberculosis, but in our climate the epidemic dies with frost. Tuberculosis never dies, and the mortality is proportionately, and in the long run actually greater than that of the yellow plague. In the present epidemic at New Orleans about 14% of the infected die, while the same figure expresses the proportion of deaths from tuberculosis to all deaths. In the city of Charleston alone in the last twelve years 3,106 people have died of this disease—a yearly average of more than 250. But it occasions no comment, not the slightest ripple of excitement. When yellow fever is threatened ordinances are passed and enforced, extraordinary efforts are made to cleanse and disinfect with unusual thoroughness, the public are taught how the dread disease is propagated and spread, and what must be done to avoid infection in case the plague should reach us. With the knowledge of past epidemics in our minds, and in full view of the injurious effects of the present epidemic, it cannot and should not be otherwise. But we plead for the same active struggle against the deadlier malady, the great hungry plague that is never absent from our borders, and is unceasing in its work of destruction. We plead for greater care on the part of physicians in making early diagnoses; for methodical instruction of the masses concerning the contagious nature of consumption and the means to be employed for its prevention; and for the application by municipal health authorities of measures for the destruction of the germs and the prevention of their spread. The notification of tubercular cases is essential for the proper carrying out of these measures, and notification should be obligatory as in the case of smallpox or diphtheria, and not left to the discretion of the attending physician. If physicians and municipal authorities would show a united front and manifest in the fight against tuberculosis an interest and energy equal to that which they display in the combat with yellow fever and smallpox and diphtheria the disappearance of consumption would be a matter of time only.

"I hold that man has already reached a position of intelligence and responsibility in which he becomes a co-worker with the Creator in the betterment of hmself and his brother. Our future lies largely in our own hands. Shall we move onward toward the promised land of human perfection, or shall we admit that life is a failure and that the race is without the opportunity of betterment? If we can make this world a fairer habitation for happier and better generation we should seek no nobler task and ask no higher reward!" VICTOR C. VAUGHN.

THE NEW PRESIDENT OF THE A. M. A.

The American Medical Association is to be congratulated upon the selection of a thoroughly practical man as President. Dr. Wm. J. Mayo, of Rochester, Minn. In addition to being a surgeon of the very first rank and one who has done as much as any man to forward American surgery by his work upon the Gall Bladder, is a charming gentleman and one well fitted to hold the Presidency of the Association.

There is one thing to be said about the American Medical Association, and that is that she seems to seek the man and not have the man seek the Association.

You may talk about the cliques in the American Medical Association, and you may talk about the two, three, four or five men power; but the fact remains and stands boldly forth, especially of recent years, that their selections for President have been of the very first order. One year we see so eminent a medical man as Dr. Musser, of Philadelphia, and the next year so eminent a surgeon as Dr. Mayo, of Rochester, at the helm.

Under the guidance of such men as these, and with the many State Journals that are now being published, it is ridiculous in the extreme to say that the American Medical Association is degenerating into a body that is run by a clique. No clique can capture an Association with every State Journal as a mouthpiece, and every well known scientific man as a factor in her well-being.

We congratulate the Association on the selection of Dr. Mayo, of Rochester.

DR. OSLER'S FAREWELL.

We publish in this issue Dr. Wm. Osler's farewell address to the Medical Profession of the United States, and sincerely trust that each and every member who receives this copy, will read it thoroughly, digest it thoroughly, and think upon it thoroughly. Unity, peace and concord is the subject of this eminent medical man's farewell, and it is well worth the time taken in the reading and the after thought and consideration thereof.

Dr. Osler has gone to accept the highest honor that it is possible to attain in the world of medicine. Being Regius Professor of Medicine at Oxford means that he has passed over all of the bridges, all of the rivers, passed all of his colleagues, and has attained the highest point upon the pinnacle of medical fame.

It is said by those who have toiled up the snowy declivities of Mt. Blanc and reached the top, that the sense of well done is the sole return for the hardships of that toilsome journey. In other words, it is the accomplishment of the feat that thrills. We trust that Dr. Osler is experiencing this most delightful of all sensations—conquest, and we wish him well; and trust that still further honors, if any, await him, will fall to his share. That he deserves them, no medical man in this broad United States of America will gainsay.

We heartily recommend his farewell address to each and every one of our readers.

FEES OF INSURANCE EXAMINERS.

In the issue of *American Medicine* of Sept. 2nd, there appears a most excellent editorial on the subject of small fees of the Medical Examiners. The editorial states that the average fees are from $1.00, $2.00 or 3.00. When we consider that this might mean to the Insurance Company thousands of dollars, the fee is farcical on its face. The Doctor who passes on the risk gets a fee absolutely disproportionate. The editorial suggests that instead of giving

$20,000 as annual retainers to men who do nothing, as was recently shown in the affairs of the Equitable, it would be far better for the Insurance Companies to pay the Medical Examiners better fees for their examinations, in order that it would pay them to take more time to make thorough examinations, and thus protect the policy holders and the Company.

The editorial suggests that the proper fee for the Medical Examiner is one-half of 1% of the face value of the policy, or even 1%, and states that such gradation of fees is in accordance with the legal custom of ages and that public policy really demands it, and if this were the case it would be an attractive specialty, and one that would attract able men to the betterment of the Company and of the insured.

AS OTHERS SEE US.

Four more State Medical organizations have started medical journals as the medium of publication of their transactions, and one, Maryland, has made an existing journal its official publication. Texas, Ohio, South Carolina and New Mexico are the States to begin the publication of new journals, and we certainly wish them the very best of success and long and useful lives. The acceptance of the journal idea by comparatively small organizations, such as South Carolina and New Mexico, is very suggestive, and is a lesson to some of the larger organizations which as yet are undecided. The fact that the members of a society can in this manner be reached every month in the year, and not merely once a year, at the annual meetings, is undoubtedly one of the strongest arguments in favor of the State organization journal. The action of the A. M. A. in establishing the Council on Pharmacy and Chemistry furnishes a good and safe guide for the benefit of those who have charge of the business management of State Medical Association Journals, and there seems little reason to doubt that they can come together on a common ground and effect an organization of State medical journals that will be of great usefulness and advantage to all. The four new journals have started right, and there is no reason why, under the advice of the Council, they should not continue right; we believe that they will, and we certainly wish them well.—*California State Journal of Medicine.*

UNITY, PEACE AND CONCORD.*

Farewell Address to the Medical Profession of the United States.

BY

WILLIAM OSLER, M. D.,

Regius Professor of Medicine, Oxford University,

OXFORD, ENGLAND.

On this occasion I have had no difficulty in selecting a subject on which to address you. Surely the hour is not for the head but for the heart, out of the abundance of which I may be able to express, however feebly, my gratitude for the many kindnesses I have received from the profession of this country during the past twenty-one years, and from you, my dear colleagues of this State and city, during the sixteen years I have dwelt among you. Truly I can say that I have lived my life in our beloved profession—perhaps too much! but whatever success I have had has come directly through it, and my devotion is only natural. Few men have had more from their colleagues than has fallen to my lot. As an untried young man my appointment at McGill College came directly through friends in the faculty who had confidence in me as a student. In the ten happy years I lived in Montreal I saw but few physicians and students, among whom I was satisfied to work—and to play. In Philadelphia the hospitals and societies absorbed the greater part of my time, and I lived the peaceful life of a student with students. An ever-widening circle of friends in the profession brought me into closer contact with the public, but I have never departed from my ambition to be first of all a servant of my brethren, willing and anxious to do anything in my power to help them. Of my life here you all know I have studied to be quiet and to do my own business and to walk honestly toward them that are without, and one of my chief pleasures has been to work among you as a friend, sharing actively in your manifold labors. But when to the sessions of sweet silent thought I summon up the past, not what I have done, but the many things I have left undone, the opportunities I have neglected, the battles I have shirked, the precious hours I have wasted—these rise up in judgment.

A notable period it has been in our history through which we have lived, a period of reconstruction and renovation, a true renaissance, not only an extraordinary revival of learning, but a complete transformation in our educational methods; and I take pride in the thought that, in

*Delivered at the annual meeting of the Medical and Chirurgical Faculty of Maryland, Baltimore, April 26, 1905. Reprinted from the Journal of the A. M. A., August 5, 1905.

Philadelphia and in Baltimore, I have had the good fortune to be closely associated with men who have been zealous in the promotion of great reforms. the full value of which we are too close to the events to appreciate. On the far-reaching influence of these changes time will not permit us to dwell. I propose to consider another aspect of our work of equal importance, neither scientific nor educational, but what may be called humanistic, as it deals with our mutual relations and with the public.

Nothing in life is more glaring than the contrast between possibilities and actualities, between the ideal and the real. By the ordinary mortal, idealists are regarded as vague dreamers, striving after the impossible, but in the history of the world how often have they gradually molded to their will conditions the most adverse and hopeless! They alone furnish the *Geist* that finally animates the entire body and makes possible reforms and even revolutions. Imponderable, impalpable, more often part of the moral than of the intellectual equipment, are the subtle qualities so hard to define, yet so potent in every-day life by which these fervent souls keep alive in us the reality of the ideal. Even in a lost cause with aspirations utterly futile, they refuse to acknowledge defeat and, still nursing an unconquerable hope, send up the prayer of faith in face of a scoffing world. Most characteristic of aspirations of this class is the petition of the Litany in which we pray that to the nations may be given "unity, peace, and concord." Century after century from the altars of Christendom this most beautiful of all prayers has risen from lips of men and women, from the loyal souls who have refused to recognize its hopelessness, with the war drums ever sounding in their ears. The desire for unity, the wish for peace, the longing for concord, deeply implanted in the human heart, have stirred the most powerful emotions of the race, and have been responsible for some of its noblest actions. It is but a sentiment, you may say, but is not the world ruled by feeling and by passion? What but a strong sentiment baptized this nation in blood, and what but sentiment, the deep-rooted affection for country which is so firmly implanted in the hearts of all Americans, gives to these States to-day unity, peace, and concord. As with the nations at large, so with the nation in particular, as with people so with individuals, and as with our profession so with its members, this fine old prayer for unity, peace and concord, if in our hearts as well as on our lips, may help us to realize its aspirations. What some of its lessons may be to us will be the subject of my address.

UNITY.—Medicine is the only world-wide profession, following everywhere the same methods, actuated by the same ambitions and pursuing the same ends. This homogenity, its most characteristic feature, is not shared by the law, and not by the church, certainly not in the same degree. While in antiquity the law rivals medicine, there is not in it that extraordinary solidarity which makes the physician at home in any country, in any place where two or three sons of men are gathered together. Similar in its high aims and in the devotion of its officers, the Christian Church, widespread as it is, and saturated with the humanitarian instincts of its Founder, yet lacks that catholicity—*urbi et orbi*—which enables the physician to practise the same art amid the same surroundings in every country of the earth. There is unity, too, in its aims—the prevention of diseases by discovering their causes, and the cure and relief of sickness and suffering. In a little more than a century a united profession working in many lands has done more for the race than has ever before been accomplished by any other body of men. So great have been these gifts that we have almost lost our appreciation of them. Vaccination, sanitation, anesthesia, antiseptic surgery, the new science of bacteriology, and the new art in therapeutics have effected a revolution in our civilization to which only can be compared the extraordinary progress in the mechanical arts. Over the latter there is this supreme advantage, it is domestic—a bedroom revolution, which sooner or later touches each one of us, if not in person, in those near and dear—a revolution which for the first time in the history of poor, suffering humanity brings us appreciably closer to that promised day when the former things should pass away, when there should be no more unnecessary death, when sorrow and crying should be no more, and there should not be any more pain.

One often hears as a reproach that more has been done in the prevention than in the cure of disease. It is true, but this second part of our labors has also made enormous progress. We recognize to-day the limitations of the art, we know better the diseases curable by medicine, and those which yield to exercise and fresh air; we have learned to realize the intricacy of the processes of disease and have refused to deceive ourselves with half knowledge, preferring to wait for the day instead of groping blindly in the dark or losing our way in the twilight. The list of diseases which we can positively cure is an ever-increasing one, the number of diseases the course of which we can modify favorably is a growing one, the number of incurable diseases (which is large and which will probably always be large) is diminishing—so that in this second point we may feel that not only is the work already done of the greatest importance, but that we are on the right path, and year by year as we know disease better, we shall be able to treat it more successfully. The united efforts of countless workers in many lands have won these greatest victories of science. Only by ceaseless co-operation and the intelligent appreciation by all of the results obtained in each department has the present remarkable position been reached. Within a week or ten days a great discovery in any part of the world is known everywhere, and, while in a certain sense we speak of German, French, English and American medicine, the differences are trifling in comparison with the general similarity The special workers know each other and are familiar with each other's studies in a way that is truly remarkable. And the knowledge gained by the one, or the special technic he may devise, or the instrument he may invent is at the immediate disposal of all. A new life-saving operation of the first class devised by a surgeon in Breslau would be performed here the following week. A discovery in practical medicine is common property with the next issue of the weekly journals.

A powerful stimulus in promoting this wide organic unity is our great international gatherings, not so much the International Congress of the profession, which has proved rather an unwieldy body, but of the special societies which are rapidly denationalizing science. In nearly

every civilized country medical men have united in great associations which look after their interests and promote scientific work. It should be a source of special pride to American physicians to feel that the national association of this country—the American Medical Association—has become one of the largest and most influential bodies of the kind in the world. We can not be too grateful to men who have controlled its course during the past ten years. The reorganization so efficiently carried out has necessitated a readjustment of the machinery of the State societies, and it is satisfactory to know that this meeting of our State Society, the first held under the new conditions, has proved so satisfactory. But in the whole scheme of readjustment nothing commands our sympathy and co-operation more than the making of the country societies, the materials out of which the State and national associations are built. It is not easy at first to work out such a scheme in full detail, and I would ask of the members of this body not only their co-operation, but an expectant consideration, if the plan at first does not work as smoothly as could be desired. On the county members I would urge the support of a plan conceived on broad national lines—on you its succcess depends, and on you its benefit will chiefly come.

Linked together by the strong bonds of community of interests, the profession of medicine forms a remarkable world-unit, in the progressive evolution of which there is a fuller hope for humanity than in any other direction.

Concentration, fusion and consolidation are welding together various subunits in each nation. Much has been done, much remains to do, and to three desiderata I may refer briefly.

In this country reciprocity between the State licensing boards remains one of the most urgent local needs. Given similar requirements, and examinations practically of the same character, with evidence of good character, the State board should be given power to register a man on payment of the usual fee. It is preposterous to restrict in his own country, as is now done, a physician's liberty. Take a case in point: A few months ago a man who is registered in three States, an able, capable practitioner of twenty years' standing, a hard student in his profession, a physician who has had charge of some of the most important lives of this country, had to undergo another examination for license. What an anomaly! What a reflection on an united profession. I would urge you all most strongly to support the movement now in progress to place reciprocity on a proper basis. International reciprocity is another question of equal importance, but surrounded with greater difficulties and, though a long way off, it will come within this century.

The second urgent need is a consolidation of many of our medical schools. Within the past twenty-five years conditions have so changed that the tax on the men in charge of the unendowed schools has become ever more burdensome. In the old days of a faculty with seven professors, a school with 300 students was a good property, paying large salaries, but the introduction of laboratory and practical teaching has so increased the expenses that very little is now left for distribution at the end of the year. The students' fees have not increased proportionately, and only the self-sacrifice and devotion of men who ungrudgingly give their time, and often their means, save a hopeless situation. A fusion of the schools is the natural solution of the problem. Take a concrete example: A union of three of the medical schools of this city would enable the scientific departments to be consolidated at an enormous saving of expense and with a corresponding increase in efficiency. Anatomy, physiology, pathology, physiologic chemistry, bacteriology and pharmacology could be taught in separately organized departments which the funds of the united school could support liberally. Such a school could appeal to the public for aid to build and endow suitable laboratories. The clinical work could be carried on at the separate hospitals, which would afford unequaled facilities for the scientific study of disease. Not only in this city, but in Richmond, in Nashville, in Columbus, in Indianapolis and in many cities a "merger" is needed. Even the larger schools of the larger cities could "pool" their scientific interests to the great advantage of the profession.

And the third desideratum is the recognition of our homeopathic brethren that the door is open. It is too late in this day of scientific medicine to prattle of such antique nonsense as is indicated in the "pathies." We have long got past the stage when any "system" can satisfy a rational practitioner, long past the time when a difference or belief in the action of drugs—the most uncertain element in our art!—should be allowed to separate men with the same noble traditions, the same hopes, the same aims and ambitions. It is not as if our homeopathic brothers are asleep—far from it—they are awake many of them at any rate—to the importance of the scientific study of disease, and all of them must realize the anomaly of their position. It is distressing to think that so many good men live isolated, in a measure, from the great body of the profession. The original grievous mistake was ours—to quarrel with our brothers over infinitesimals was a most unwise and stupid thing to do. That we quarrel with them now is solely on account of the old shibboleth under which they practice. Homeopathy is as inconsistent with the new medicine as is the old-fashioned polypharmacy, to the death destruction of which it contributed so much. The rent in the robe of Æculapius, wider in this country than elsewhere, could be repaired by mutual concessions—on the one hand by the abandonment of special designations, and, on the other, by an intelligent toleration of the therapeutic vagaries which in all ages have beset the profession, but which have been mere flies on the wheels of progress.

PEACE.—Many seek peace, few pursue it actively, and among these few we, alas! are not often to be found. In one sense every one of us may be asked the question which Jehu returned to Joram: "What hast thou to do with peace?' since our life must be a perpetual warfare, dominated by the fighting spirit. The physician, like the Christian, has three great foes—ignorance, which is sin; apathy, which is the world, and vice, which is the devil. There is a delightful Arabian proverb, two lines of which run: "He that knows not and knows not that he knows not is a fool—shun him. He that knows not and knows that he knows not is a simple—teach him." To a large extent these two classes represent the people with whom we have to deal. Teaching the simple and suffering the fools gladly, we must fight the wil-

ful ignorance of the one and the helpless ignorance of the other, not with the sword of righteous indignation, but with the skillful weapon of the tongue. On this ignorance the charlatan and the quack live, and it is by no means an easy matter to decide how best to conduct a warfare against these wily foes, the oldest and most formidable with whom we have to deal. As the incomparable Fuller remarks: "Well did the poets feign Æsculapius and Circe brother and sister, * * * for in all times (in the opinion of the multitude)witches, old women and imposters have had a competition with doctors." Education of the public of a much more systematic and active kind is needed. The congress on quackery, which is announced to take place in Paris, with some twenty-five subjects for discussion, indicates one important method of dealing with the problem. The remarkable exhibit held last year in Germany of everything relating to quacks and charlatans did an immense good in calling attention to the colossal nature of the evil. A permanent museum of this sort might well be organized in Washington in connection with the Department of Hygiene. It might be worth while to imitate our German brethren in a special national exhibit, though I daresay many of the most notorious sinners would apply for large space, not willing to miss the opportunity for a free advertisement! One effective measure is enforced in Germany. Any proprietary medicine sold to the public must be submitted to a government analyst, who prepares a statement (as to its composition, the price of its ingredients, etc.), which is published at the cost of the owner of the supposed remedy in a certain number of the daily and weekly papers.

By far the most dangerous foe we have to fight is apathy—indifference from whatever cause, not from a lack of knowledge, but from carelessness, from absorption in other pursuits, from a contempt bred of self-satisfaction. Fully 25 per cent. of the deaths in the community are due to this accursed apathy, fostering a human inefficiency, and which goes far to counterbalance the extraordinary achievements of the past century. Why should we take pride in the wonderful railway system with which enterprise and energy have traversed the land when the supreme law, the public health, is neglected? What comfort in the thought of a people enjoying great material prosperity when we know that the primary elements of life (on which even the old Romans were our masters) are denied to them. What consolation does the "little red school house" afford when we know that a Lethean apathy allows toll to be taken of every class from the little tots to the youth and maidens? Western civilization has been born of knowledge, of knowledge won by hard, honest sweat of body and brain, but in many of the most important relations of life we have failed to make that knowledge effective. And strange irony of life, the lesson of human efficiency is being taught us by one of the little nations of the earth, which has so far bettered our instruction that we must again turn eastward for wisdom. Perhaps in a few years our civilization may be put on trial, and it will not be without benefit if it arouses the individual from apathy and makes him conscious of the great truth that only by earnest individual human effort can knowledge be made effective, if it arouses communities from an apathy which permits medieval conditions to prevail without a protest.

Against our third great foe, vice in all its forms, we have to wage an incessant warfare, which is not less vigorous because of the quiet, silent kind. Better than any one else the physician can say the word in season to the immoral, to the intemperate, to the uncharitable in word and deed. Personal impurity is the evil against which we can do most good, particularly to the young, by showing the possibility of the pure life and the dangers of immortality. Had I time, and were this the proper occasion, I would like to arouse the profession to a sense of its responsibility toward the social evil—the black plague which devastates the land. I can but call your attention to an important society, of which Dr. Prince Morrow of New York is the organizer, which has for one of its objects the education of the public on this important question. I would urge you to join in a crusade quite as important as that in which we are engaged against tuberculosis.

CONCORD.—Unity promotes concord—community of interests, the same aims, the same objects give, if anything can, a feeling of comradeship, and the active co-operation of many men, while it favors friction, lessens the chances of misunderstanding and ill-will. One of the most gratifying features of our professional life is the good feeling which prevails between the various sections of the country. I do not see how it could be otherwise. One has only to visit different parts and mingle with the men to appreciate that everywhere good work is being done, everywhere an earnest desire to elevate the standard of education, and everywhere the same self-sacrificing devotion on the part of the general practitioner. Man will tell you that commercialism is rife, that the charlatan and the humbug were never so much in evidence, and that in our ethical standards there has been a steady declension. These are the Elijahs who are always ready to pour out their complaints, mourning that they are not better than their fathers. Few men have had more favorable opportunities than I have had to guage the actual conditions in professional private life, in the schools, and in the medical societies, and as I have seen them in the past twenty years I am filled with thankfulness for the present and with hope for the future. The little rift within the lute is the absence in many places of that cordial professional harmony which should exist among us. In the larger cities professional jealousies are dying out. Read Charles Caldwell's "Autobiography" if you wish for spicy details of the quarrels of the doctors in the first half of the last century in this country. I am sorry to say, the professors have often been the worst offenders, and the rivalry between medical schools has not always been friendly and courteous. That it still prevails to some extent must be acknowledged, but it is dying out, but not so rapidly as we could wish. It makes a very bad impression on the public, and is often a serious stumbling block in the way of progress. Only the other day, I had a letter from a most intelligent and appreciative layman who was interested in a large hospital scheme about which I had been consulted. I quote this sentence from it in sorrow, and I do so because it is written by a strong personal friend of the profession, a man

who has had long and varied experience with us: "I may say to you that one of the distressing bewilderments of the layman who only desires the working out of a broad plan is the extraordinary bitterness of professional jealousy between not only school men and non-school men, but between school men themselves, and the reflections which are cast on one another as belonging to that clique, which makes it exceedingly difficult for the layman to understand what way there is out of these squabbles."

The national and special societies, and particularly the American Medical Association, have brought men together and have taught them to know each other and to appreciate the good points which at home may have been overlooked. As Dr. Brush said yesterday in his address, it is in the smaller towns and country districts that the conditions are most favorable for mutual misunderstandings. Only those of us who have been brought up in such surroundings can appreciate how hard it is for physicians to keep on good terms with each other. The practice of medicine calls equally for the exercise of the heart and the head, and when a man has done his best, to have his motives misunderstood and his conduct of a case harshly criticised, not only by the family, but by a colleague who has been called in, small wonder when the opportunity arises, if the old Adam prevails and he pays in kind. So far as my observation goes there are three chief causes for the quarrels of doctors. The first is lack of proper friendly intercourse by which alone we can know each other. It is the duty of the older man to look on the younger one who settles near him not as a rival, but as a son. He will do to you just what you did to the old practitioner, when, as a young man, you started—get a good many of your cases; but if you have the sense to realize that this is inevitable, unavoidable and the way of the world, and if you have the sense to talk over, in a friendly way, the first delicate situation that arises, the difficulties will disappear and recurrences may be made impossible. The young men should be tender with the sensibilities of their seniors, deferring to their judgment and taking counsel with them. If young graduates could be taken more frequently as assistants or partners, the work of the profession would be much lightened and it would promote amity and good fellowship. A man of whom you may have heard as the incarnation of unprofessional conduct, and who has been held up as an example of all that is pernicious, may be, in reality, a very good fellow, the victim of petty jealousies, the mark of the arrows of a rival faction, and you may, on acquaintance, find that he loves his wife and is devoted to his children, and that there are people who respect and esteem him. After all, the attitude of mind is the all-important factor in the promotion of concord. When a man is praised, or when a young man has done a good bit of work in your special branch, be thankful—it is for the common good. Envy, that pain of the soul, as plato calls it, should never for a moment afflict a man of generous instincts and who has a sane outlook in life. The men of rival schools should deliberately cultivate the acquaintance of each other and encourage their students and the junior teachers to fraternize. If you hear that a young fellow just starting has made mistakes or is a little "off color," go out of your way to say a good word to him, or for him. It is the only cure; any other treatment only aggravates the malady.

The second great cause is one over which we have direct control. The most widespread, the most pernicious of all vices, equal in its disastrous effects to impurity, much more disastrous often than intemperance, because destructive of all mental and moral nobility, as are the others of bodily health, is uncharitableness—the most prevalent of modern sins, peculiarly apt to beset all of us, and the chief enemy to concord in our ranks. Oftentimes it is a thoughtless evil, a sort of tic or trick, an unconscious habit of mind and tongue which gradually takes possession of us. No sooner is a man's name mentioned than something slighting is said of him, or a story is repeated which is to his disadvantage, or the involuntary plight of a brother is ridiculed, or even his character is traduced. In chronic and malign offenders literally "with every word a reputation dies." The work of a school is disparaged, or the character of the work in a laboratory is belittled; or it may be only the faint praise that damns, not the generous meed from a full and thankful heart. We have lost our fine sense of the tragic element in this vice, and of its debasing influence on the character. It is interesting that Christ and the apostles lashed it more unsparingly than any other. Who is there among us who does not require every day to lay to heart that counsel of perfection; "Judge not according to the appearance, but judge righteous judgment." One of the apostles of our profession, Sir Thomas Browne, has a great thought on the question:

"Whilst thou so hotly disclaimest the evil, be not guilty of diabolism. Fall not into one name with that unclean spirit, nor act his nature who thou so much abhorest; that is, to accuse, calumniate, backbite, whisper, detract, or sinistrously interpret others. Degenerous depravities, and narrow-minded vices! not only below St. Paul's noble Christian, but Aristotle's gentleman. Trust not with some that the Epistle of St. James is apocryphal, and so read with less fear that stabbing truth, that in company with this vice thy religion is in vain. Moses broke the tables without breaking of the law; but where charity is broke the law itself is shattered, which can not be whole without love, which is the fulfilling of it. Look humbly upon thy virtues; and though thou are rich in some, yet think thyself poor and naked without that crowning grace, which thinketh no evil, which envieth not, which beareth, hopeth, believeth, endureth all things. With these sure graces, while busy tongues are crying out for a drop of cold water, mutes may be in happiness, and sing the Trisagion in heaven.

And the third cause is the wagging tongue of others who are too often ready to tell tales and make trouble between physicians. There is only one safe rule—never listen to a patient who begins with a story about the carlessness and inefficiency of Dr. Blank. Shut him or her up with a snap, knowing full well that the same tale may be told of you a few months later. Fully half of the quarrels of physicians are fomented by the tittle tattle of patients, and the only safeguard is not to listen. Sometimes it is impossible to check the flow of imprecation and slander, and then apply the other rule—perfectly safe, anl which may be commended as a good practice—never believe what a patient tells you to the de-

triment of a brother physician, even though you may think it to be true.

To part from the profession of this country and from this old faculty, which I have learned to love so dearly, is a great wrench, one which I would feel more deeply were it not for the nearness of England, and for the confidence I feel that I am but going to work in another part of the same vineyard, and were it not for the hope that I shall continue to take interest in your affairs and in the welfare of the medical school to which I owe so much. It may be that in the hurry and bustle of a busy life I have given offense to some—who can avoid it? Unwittingly I may have shot an arrow o'er the house and hurt a brother—if so, I am sorry and I ask his pardon. So far as I can read my heart I leave you in charity, with all. I have striven with none, not, as Walter Savage Landor says, because none was worth the strife, but because I have had a deep conviction of the hatefulness of strife, of its uselessness, of its disastrous effects, and a still deeper conviction of the blessings that come with unity, peace and concord. And I would give to each of you, my brothers—you who hear me now, and to you who may elsewhere read my words—to you who do our greatest work laboring, incessantly for small rewards in towns and country places—to you the more favored ones who have special fields of work—to you teachers and professors and scientific workers—to one and all, throughout the length and breadth of the land—I give a single word as my parting commandment:

"It is not hidden from thee, neither is it far off. It is not in heaven that thou shouldst say, 'Who shall go up for us to heaven, and bring it unto us that we may hear it and do it?' Neither is it beyond the sea that thou shouldst say, 'Who shall go over the sea for us and bring it unto us that we may hear it and do it?' But the word is very nigh unto thee, in the mouth and in thy heart, that thou mayest do it—Charity."

ORIGINAL ARTICLES.

FOREIGN BODIES IN THE LARYNX, TRACHEA AND BRONCHI.

DR. H. R. BLACK, SPARTANBURG, S. C.

By sudden inspiration a foreign body, usually while being held in the mouth, is drawn into the air passage. Immediately it excites a violent paroxysm of coughing, and the body is ejected—producing no effect except a momentary sense of suffocation—or, if it becomes impacted, it may cause immediate death by occlusion of the glottis; elsewhere, it gives rise to acute inflammation, ulceration, great swelling and suppuration, with all the symptoms of laryngial stenosis, as pain, cough, dyspnoea and aphonia. With the laryngoscope the body may be seen above or below the vocal chords, and removed with a pair of laryngeal forceps, guided by the mirror, but this is hardly possible in young children. However, with the tip of the left index finger resting upon the body, or immediately behind it as a guide, the body can usually be extracted with a pair of long forceps.

If in the trachea a loud rhonchous may be heard on oscultation, a deep expiration will give rise to a severe cough with violent dyspnoea.

A foreign body impacted in a bronchus is always a grave accident, and is indicated by localized pain and cough. The respiratory murmur of one lung, or lobe, is lost, according to the location of the body. If it remains impacted, it gives rise to serious pulmonary changes, i. e., septic bronchitis, pneumonia, gangrene, suppuration, etc., and the patient is lost, or, after a prolonged illness, it is finally coughed up and the patient makes a recovery.

These are a few of the prominent symtoms of foreign bodies in the air passage—a full description of which will be found in any of our text-books on surgery.

REPORT OF CASE.

CASE 1.—May 10th, 1903, a colored lad, aged seventeen years, came to my office with a cockle-burr in the larynx. There was much pain and a very rough cough, and loss of voice.

After the throat was cocainized, a dark body could be seen—by the aid of a mirror—lying between the vocal chords anteriorly.

The mouth-gag was inserted and held securely in position by an assistant. The tip of the left index finger was carried down into the larynx, and brought directly in contact with the foreign body, which was easily and quickly removed with a pair of long forceps. This patient was referred to me by Dr. W. J. Wall, Inman, S. C.

The accident happened while the lad was plowing—the single-tree dislodging the burr from the bush, it flew into his

mouth and was drawn into the larynx before the lad could recover himself.

CASE 2.—November 15, 1903, Clarence S———, white, age seven years, while holding a cockle-burr between his teeth, blowing and drawing the air through it, sucked it into the larynx. He was brought to my office by Dr. Parsons, of Woodruff, S. C. He was suffering from the usual symptom—pain, hoarseness, loss of voice, cough, swelling, dyspnoea, etc.

In the erect position, seated on his father's lap with a sheet thrown over his chest and front to assist in controlling his arms, and with the mouth-gag secured in position by Dr. Parsons, the burr was located imbedded in the right chord by the tip of the finger. It was easily removed in the manner as above described.

CASE 3.—A colored boy, aged seven years, was referred to me by Dr. Wm. F. Smith, of Glenn Springs, S. C., with a cockle-burr in his throat—January, 1904. It was lying well between the vocal chords, and was recognized and extracted in the usual manner twenty-four hours after it had been drawn into the larynx.

CASE 4.—September, 1904, S. W——, a negro lad of seventeen summers, while walking through a field, struck a cockle-burr bush with his foot, dislodging one, which flew into his mouth and was drawn into the larynx. Pain, cough, swelling, dyspnoea and aphonia immediately followed. In the proper position, with the mouth well open, the operator's left index finger was passed well down into the throat, and the tip made to sweep over the entire field—I thought—but failed to locate the body. Another effort was made, carrying the tip of the finger directly down upon the crycoid cartilage, then bringing it directly forward, well down into the larynx. I detected the burr deeply imbedded anteriorly between the chords. I then pushed the point of a pair of McKenzie's long forceps down over the palmer surface of the finger until they came in contact with the foreign body, at which moment the patient brought a most violent and terrific cough, which dislodged the burr, and he blew it out of his mouth.

In looking for a foreign body in the air passage, never open the wind-pipe until you are quite sure that it is not somewhere impacted in the larynx. If in the upper portion, or between the chords, you can usually remove them as I have indicated—guided by a mirror—cocaine to the pharynx and larynx will facilitate this measure—otherwise, you can choose between thyrotomy, laryngotomy and tracheotomy.

Cockle-burrs are usually imbedded in the chords, or the soft parts above. The needles take hold of the tissue whenever they meet the slightest resistance.

CASE 5.—January 31, 1905. Dr. W. G. Sexton asked me to see S. H———, white, female—aged nineteen months—whose parents said she had swallowed a safety-pin. At the time of my visit, there was no objective evidence of a foreign body in the throat, except a profuse flow of saliva. With the child securely held, in the proper position, I passed my finger into the throat, where I felt the pin, and the same was quickly removed. The pin was open.

CASE 6.—Brandon H———, aged four years, white, was referred to me by Dr. J. W. Bramlett, of Campobello, S. C., May 14, 1903, in the early part of the night, with a grain of corn impacted in the right bronchi at the bifurcation. He came to me seven days after the accident. His condition was a very distressed one, and, apparently, he could not survive many hours.

Drs. Dean and Jeffries were requested to assist in the operation. In an hour's time, the little fellow was lying upon the table with his wind-pipe open. The grain of corn was immediately blown out, and fell upon the floor.

The wound was cleansed and a tracheotomy tube inserted. The patient was dressed and put to bed. At the end of twenty-four hours, the tube was removed and the wound was dressed sufficiently thereafter to keep clean. He made a quick recovery and left for his home—eighteen miles away on the eighth day. There was no indication of inflammation or pneumonia at the time of the operation, or at any time thereafter—due, per-

haps, to the fact that the grain of corn had been boiled. The reader, however, can decide that for himself.

CASE 7.—January 1st, 1905, Hilder P———, white, age nineteen months, was referred to me by Dr. Parsons, of Woodruff, S. C., with the history of a foreign body of eight days duration in the throat. The nature of which was uncertain. While playing with a basket of nuts, the child became suddenly choked, almost strangulated, turned black in the face. The nurse was uncertain as to what had happened, but said that she thought that she saw something black go down the child's throat. Evidently, there was something in the larynx. The child was hoarse, could not speak above a whisper, and the breathing was difficult and quick, the pulse rapid, the temperature 98°.

I ordered her sent to the Spartanburg Hospital for an operation, which was complied with immediately. Drs. Heinitsh, Jeffries and Sexton were summoned to assist in the operation.

While the patient was held in the lap of one of the physicians, and the mouth-gag held by another, I passed the left index finger down into the larynx, where I could feel the sharp end of a foreign body with the tip of the finger. It was situated deeply, anteriorly, and just below the vocal chords. I made a single effort to extract it through the mouth, but in this I failed, and feared that I might push it farther down.

After some delay, the child was placed upon the operating table, and tracheotomy performed in the usual way—high operation. After incising the two first rings, a half-ounce of pus rolled out of the trachea. Sponging this away, a bright-looking substance—apparently, a nail—came into view. This object was removed with a pair of hoemastats, and proved to be a poultry wire staple—like the one I pass around.

A tracheotomy tube was left in position. The temperature went up to 101° and the pulse to 120. At the end of twenty-four hours, the tube was removed, the temperature dropped, and the pulse slowly returned to its normal beat.

The child made a fine recovery and left the hospital on the eighth day.

While discussing foreign bodies in the larynx, or air passage, I beg to report briefly eight more cases of intubation.

At the Association meeting in Spartanburg, S. C., three years ago, I reported four cases—three recoveries and one death. The latter was due to the lack of antitoxin, and the tube was not inserted until after the child had been desperately ill for more than a week.

CASES OF INTUBATION.

CASE 5.—Wm. F. T———, white, aged four years. Diagnosis—laryngeal diphtheria. This was a patient of Dr. T. D. Hairston, of Clifton No. 1, six miles east of Spartanburg, S. C. The patient was intubated November 12, 1902, and extubated five days thereafter. His recovery was speedy and complete.

CASE 6.—November 23, 1902, I was called by Dr. Walker, of Glendale, a mill town six miles east of Spartanburg, S. C., to intubate Randolph W———, white, aged ten months, the youngest I have ever seen with diphtheritic laryngitis.

Both tonsils were covered with the deposit, and the little fellow's condition was very alarming. The tube was inserted and in a few moments he fell asleep, and relief was complete. On the fifth day it was removed, only to be re-inserted. Two days later, it was again removed, but in an hour's time the breathing had become so labored that the tube had to be re-inserted for the third time. On the tenth day, it was finally extubated, and the patient made a happy recovery.

The younger the patient, the longer the tube must remain in the larynx. Notwithstanding the presence of the tube in the larynx, young children nurse about as well with a tube as they do without one.

CASE 7.—October 22, 1903, I was called by Dr. Allen, of Cedar Springs, S. C., to intubate the two-year old daughter of Wm. V. White. Diagnosis:—Laryngeal croup.

In less than ten minutes after my arrival, I had placed a tube in the larynx.

It was coughed out on the fourth day; the child was relieved and made a quick recovery.

CASE 8.—September 23, ——, I was requested by Dr. J. L. Jeffries, of Spartanburg, S. C., to intubate the four-year old son of Ozra L———. Diagnosis:—Malignant diphtheritic laryngitis.

The tube was introduced on the seventh day of illness, but did not afford relief. The dyspnoea continued, due, perhaps, to the fact that the tube did not extend beyond the obstruction. Possibly it was cardiac, or due to toxaemia. However, the child was thoroughly septic. There was great swelling of the cervical lymph glands, and infiltration of the cellular tissue. The exudate, a dirty gray, covered both tonsils and the uvula. The pulse was rapid, feeble and compressible.

The tube was removed in less than an hour, and the little patient died on the following day. During the intervening hours, the distress was great. This child was subject to attacks of tonsilitis, for which reason the calling of a physician was delayed until the sixth day of its illness.

Antitoxine was given freely, but too late.

CASE 9.—Jessie S———, aged two years, patient of Dr. W. G. Sexton, Spartanburg, S. C., was intubated October 8th, 1903, and extubated five days thereafter. Recovery was very prompt.

CASE 10.—October 20, 1903, I was summoned to the bedside of J. S. H———, Jr., aged four years, white, at Clifton, No. 1, a mill town six miles east of Spartanburg, S. C., in consultation with Dr. T. D. Hairston. The doctor did not see this child until the day before—which was the seventh day of its illness. No antitoxine had been given, of course. Suffocation was threatening; a tube was placed in the larynx, from which there was no relief. The tube was removed in less than an hour, and the child laid upon a table and tracheotomy performed. Death was very prompt in its relief.

CASE 11.—R. W. White, male, aged one year, patient of Dr. G. H. Bunch, Spartanburg, S. C., was intubated February 11, 1904.

On the third, fourth and fifth days, respectively, thereafter the tube was coughed up. At three o'clock A. M., a larger one was introduced, only to be coughed out at four different times—making seven times in all—and was finally disposed of on the eleventh day, the little fellow making a complete recovery.

CASE 12.—Son of P. W———, white, age nineteen months, of Pacolet Mills, twelve miles east of Spartanburg, S. C.; patient of Dr. Kirkpatrick, was intubated January 23, 1905.

The tube was removed on the seventh day; the dyspnoea returned, and the patient was re-intubated in less time than an hour. Two days later, the tube was coughed up; the breathing again became labored, and after a twelve-mile drive at a 2.40 gait—the tube was re-inserted.

On the twelfth day, the tube was again coughed up and disposed of, and a complete recovery followed.

DISCUSSION.

DR. C. M. WALKER:—My cases generally die before the 7th day. It seems to me the 7th day is a little late for intubation in cases of membraneous croup.

DR. D. M. CROSSLAND:—I have listened with interest to Dr. Black's paper, as I have had my experience with foreign bodies in the throat. Sometime ago a man came hurriedly to me, and stated that while eating fish for breakfast he had gotten a fishbone in his throat. I examined his throat in every conceivable way and could not detect the bone, but he still said it was there. Not knowing what better to do, I took a piece of sponge, and wet it, and ran it down his throat and brought it back, and the fish bone was sticking in the sponge. He was relieved, and satisfied.

These things some time give you trouble. Some time ago I had a little child to swallow a small cartridge shell, and I had considerable trouble to get it out.

DR. MONSEN:—It is a fact worthy of note that reports of cases are usually uninteresting, but when they are reported in this way, so briefly, giving the rest of us credit for knowing a good deal, too, then they become interesting, and we can follow as lengthy a paper as this, with report of cases, with interest to the last. I think Dr. Black deserves credit for reporting cases in this way, and think it should be encouraged. When he gives us credit for knowing something; puts his finger down and immediately removes it and goes on to the next case, that makes it interesting to a body of men supposed to be educated.

DR. W. P. DENDY:—I want to thank Dr. Black for what he has said on intubation. I have been

attending the meetings of the Association for years and this is the first I have heard on it. We doctors who live in small towns know the importance of it. You see a child suffering, choking to death, and use a tube, and you know what appreciation you get. The cases we used to get before we had antitoxin all died, but now it is my experience, with 6 or 8 cases lately, we save every one of them with tube and antitoxin. If a country doctor wants the mothers to love him, if he gets an intubation case and carries it around with him he will accomplish that result.

DR. W. P. PORCHER:—I cannot help congratulating Dr. Black on his extraordinarily good fortune, in being able first to diagnose and locate a foreign body in the larynx. and second to be able to remove it with the aid of forceps and without a laryngeal mirror. In fact I might say that I do not know, in my acquaintance with the laryngologists, of a foreign body ever being diagnosed below the vocal chords and without the laryngeal mirror. As a rule these foreign bodies are located above the vocal chords, very often upon them, and are removed with the aid of the mirror and forceps.

There was a woman, a very noted character, in Vienna, who would allow students, and especially those who had some acquaintance with the manipulation, to put a bead down on her vocal chords and remove it with the forceps. She used to charge forty cents, one gulden, for each operation, for the practice. When she found there was one who was at all skilled in the manipulation, she would allow them to do it for demonstration purposes. But she had wonderful tolerance of the vocal chords for presence of a foreign body.

A year ago I reported the case of a child who had sucked a small, green pine burr into the larynx,—or, she got it into her throat, and it had been pushed there by the physician passing his finger in, trying to get it out. The great danger of using the finger is the danger of shoving the foreign body into the larynx, and perhaps into the bronchial tubes, followed by foreign body pneumonia. The pine burr had stayed in there long enough to be softened, the leaves being turned down, while endeavoring to catch it with the forceps the leaves would pull off, leaving the body in there. The father insisting that I continue my efforts to get it out, contrary to my own advice, the very thing occurred that I feared: it went into the larynx and the patient stopped breathing. I put a tracheotomy tube in. and the following day the pine burr was removed through the natural passages.

The point is this. Dr. Black states these tubes were applied and removed on the following day. One week after this tube was put in position, Dr. Rhett saw the case with me, and thought the tube could be removed in 36 hours. We attempted it, and the breathing stopped, and we had to replace the tube. At the end of a week it was attempted, but it was 21 days before the tube could be removed with any chance of the patient's life. I am glad to say the patient got well, and is a hale, hearty child.

I congratulate Dr. Black on his good luck.

DR. WHALEY:—Dr. Porcher has mentioned a celebrated character in Vienna with whom I was acquainted. She was a wonderful woman. She would take a piece of bone, about the size of a buck-shot, and would put it in any one of the folds you wanted to take it out of. Her charge was forty cents an hour. It is said that woman taught more men how to operate in the larynx than any physician that ever lived. She was a wonderful woman, and I do believe she ought to have a monument.

DR. G. B. EDWARDS:—I have listened to Dr. Black's remarks with interest. We had an epidemic a few years ago in our town. The first case was sporadic, and naturally there was some difficulty in making a diagnosis. In that case, unfortunately, the membrane appeared low down, and appeared to be an ordinary case of tonsilitis, and before we knew it the other symptoms appeared, and we tried intubation without any success, and the only thing left for us was tracheotomy. My brother and myself performed the operation. and in that case we saved the patient by tracheotomy.

In regard to coughing up the tube. I was called in the country to a child that had been operated on and had coughed up the tube, and I used another tube and got relief. That was late in the afternoon. The next morning, about four o'clock, I was sent for again. I sent off to another town and got another tube, and when I got there I found the child was considerably relieved, and I advised against introducing the tube again, and the child recovered. Twelve hours before, death seemed inevitable without intubation.

DR. BLACK:—I first want to thank the gentlemen for their kind and complimentary remarks in reference to my operations on the larynx especially. Why Dr. Porcher was not able to get rid of his tube any earlier than 21 days I don't know, but the tracheotomy tube in the larynx is a foreign body and I believe should be disposed of as soon as possible. However, there might be as much difficulty in disposing of a tracheotomy tube as there is sometimes in disposing of an intubation tube, because, while it has not happened in my experience, tubes in the larynx have been worn 30 to 60 days, and some, I believe, 90 days. However, I would suggest that whenever you put the tracheotomy tube in the trachea you get rid of it as early as possible, and make your effort the following day.

As to a shot lying on the vocal chords, or any of its folds, I don't care to have any one come to me to try my skill on that line, but if called I will do my best, and I don't wonder that the patient died, if it is the same case Dr. Whaley referred to. I would like to know if that patient died with a shot somewhere in the larynx, or one of its ramifications?

DR. WHALEY:—She has since died, of old age, I believe.

GASTROSTOMY IN STRICTURE OF THE ESOPHAGUS, WITH THE REPORT OF A CASE.

BY

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By gastrostomy is meant the establishment of a more or less permanent fistula opening into some part of the anterior

wall of the stomach for the purpose of alimentation or surgical treatment.

It is almost always performed in esophageal stenoses for the purpose of feeding.

It is a development of modern abdominal surgery and may be regarded as one of the most humane operations, having for its object the aberation of the pangs of hunger and the amelioration of the sufferings of death from inanition.

The operation was first suggested by Egeberg, a Norwegian, in 1837, and was first performed by Sedillot, of Strasburg, in 1849.

The early operations upon the stomach for artificial feeding were almost invariably fatal. According to statistics collected by Gross up to 1884, the operation was attended by a mortality of 29.47. Senn estimates it at 25%.

As in most of the other life saving abdominal operations experience proves that it should not be regarded in the light of a 1st resort.

A review of the literature of the subject shows that the earlier operations have been performed under the most unfavorable conditions. Too often it has been put off until the patient, scarcely able to swallow liquids, is just kept alive by enemata.

Such patients worn out by the sufferings of slow starvation, and their strength reduced to the lowest ebb, by rapidly increasing emaciation, are not in a favorable condition to withstand the shock of abdominal section and plastic operation on the stomach.

As Jacobson puts it after an experience of gastrostomy performed twelve times, in each case for cancer of the esophagus, "I do not think that I exaggerate if I say that in a distinct proportion of the cases, in which the surgeon is asked to perform gastrostomy the hand of death is already on the patient, and something next door to the decomposition of the grave has already set in, owing to the extension of the disease."

The indications for gastrostomy are generally clear. The operation is demanded when the passage of food to the stomach is so obstructed as to interfere seriously with nutrition, but it is advisable to make a gastrostomy for fistula much earlier than this.

In fact many authorities believe in performing the operation in cancerous stricture long before deglutition becomes difficult.

The circumstances under which gastrostomy may be indicated, are:—

1. Certain cases of cancerous stricture. This includes invasion of the esophagus, secondarily from primary cancer of the mediastinal glands.

2. Cancerous disease of the pharynx, and in a few cases malignant disease of the tonsil or back of the tongue not admitting of operation.

3. Cicatricial stricture, whether traumatic of syphilitic.

In stricture of the esophagus due to cancer, the operation of gastrostomy is manifestly only a palliative procedure, intended to prolong life and avert the suffering of a slow starvation, until such time as it may be terminated by progressive exhaustion or extension of the original cause of the disease.

No comparison can yet, however, be made in this class of cases between the operation of gastrostomy and treatment by tubes or other methods of dilatation, for the reason that the operation has heretofore been performed under the most unfavorable conditions, and reliable statistics are not available.

Even though dilatation be resorted to in such cases the time will probably come when tubes can no longer be employed, because of the tightness of the contraction, and the danger arising from hemorrhage or perforation in the effort.

If gastrostomy be deferred until such conditions be reached, it can be performed only with greatly increased risk and as a forlorn hope.

In cicatricial stricture the methods of treatment offer a wider field for gastrostomy than that of palliation only.

1. Direct dilatation, by dilating bougies or instruments of increasing sizes passed directly from the mouth through the narrowed esophagus, the stricture being gradually dilated.

2. Direct divulsion, by the passage from the mouth in quick succession of increasing sizes of dilators, thus rupturing, in a minor degree, the surrounding constricting tissues.

3. Division of the stricture by string friction, (Byant's operation).

4. Permanent tubage.

5. Internal esophagotomy.

In some cases, however, none of these methods can be employed, many of them come under the care of the surgeon after the contraction has become so extreme that it is impossible at once to pass an instrument from the mouth, a proceeding necessary to the employment of any of the methods proposed.

In other cases the irritation caused by the organic stricture may not only exaggerate the degree of constriction by exciting spasm of the muscular fibres of the tube in the immediate vicinity of the structure but also at points remote from the seat of organic lesion.

In this class of cases gastrostomy is a natural deduction from the difficulties enumerated.

By setting the oesophagus at rest for a time some of these complications are overcome as in the almost parallel case of stricture of the urethra.

In the mean time nutrition can be maintained by direct gastric alimentation.

Retrograde dilatation of the stricture may be resorted to. Here the dilating instrument is passed from below through a gastrostomy wound in cases where but one sitting of the retrograde method is necessary followed by the immediate closure of the stomach wound, or through a gastrostomy wound where frequent resorts to the method are necessary.

Dilatation may be begun by passage of the instrument from the stomach through the strictured esophagus, but it is often commenced by causing the patient to swallow prior to anaesthesia, a thread with a split shot attached. This is found in the stomach, and upon it the dilating rubber tubes or other instruments are drawn from the mouth through the aesophagus out of the stomach wound or *vice versa.*

In the same manner division of the aesophageal stricture by string friction (after Abbe's method) may be performed, after preliminary gastrostomy is done, and recovery from the operation has taken place.

The operation of gastrostomy may be done in one or two stages—where haste is a consideration the opening must be made into the stomach as soon as the latter is attached to the abdominal wall. Where haste is unnecessary the stomach is first attached to the opening in the anterior abdominal wall; from three to five days given for union to take place,shutting off the peritoneal cavity, and then the stomach is opened.

There is little objection to establishing the fistula at once if the peritoneum is tightly approximated to the wound.

In many cases of gastrostomy for esophogeal stricture the patient has been starved so long that it is extremely desirable to feed him at once. The risk from opening the stomach are so slight in such cases that it seems desirable to make the opening immediately in spite of the slightly increased risk.

Much difference of opinion seems to exist as to the proper placing of the incision of the skin in the first step of the operation.

However, these opinions differ, it would seem the chief object to be attained is that muscles should be divided in their cleavage line in so far as this is possible and the abdominal nerves should be spared so far as is practicable.

A disadvantage of all oblique incisions parallel with and just below the left Costtal arch is the difficulty in making an intro-muscular separation of the fibres. Experience has brought the incision nearer to the vertical. Jacobson, as a result of his experience in twelve cases, prefers as simpler than the oblique, a straight vertical incision beginning opposite the end of the eighth intercostal space and passing down for three inches over the rectus, that is about two inches from the linea alba.

According to Bickham the orginal Ssabamajew-Frank incision, has been

modified in this respect and is now less oblique.

The patient should be placed supine on the table, with the abdominal parietes relaxed by slight elevation of the shoulders and slight flexion of the hips, the very prominent angle formed between the ribs and the sunken umbilical region, offering one of the difficulties in the performance of the operation.

The fibres of the rectus being exposed are torn straight through with a director, and the posterior, somewhat concave, layer of its sheath exposed. This is carefully divided for the full length of the incision and the extra peritoneal fat (if present) and the peritoneum picked up and opened together. A finger is now introduced to feel for the stomach.

In all methods of gastrostomy care must be taken not to mistake the colon for the stomach. This error has been made by several surgeons.

There is generally no difficulty whatever in recognizing the characteristic appearance of the anterior wall. In most cases the stomach presents itself immediately at the incision, if the latter is made well above the umbilicus, whether in the median line or to the left.

The difficulties arising from contraction of the stomach in prolonged starvation may be great. As a rule the contracted stomach lies high up under the left lobe of the liver and requires to be hooked downwards and forwards into the wound.

Not infrequently the great omentum presents first, and it is easy by seeking too low down to draw up the colon.

In case of difficulty the best plan is to find the anterior border of the liver, trace up the under surface to the portal fissure, and then along the lesser omentum to the stomach.

This is told by its thicker, more substantial feel and pink red color.

The stomach being drawn up, a part is chosen on its anterior surface free from vessels, and as near as possible to the Cardiac end.

A number of different methods of completing the operation have been divised, the object being to prevent regurgitation of stomach contents, by producing the longest, most indirect and most valvular canal possible between the stomach and abdominal openings.

The greater the degree reached in obtaining this object the greater the control over the gastric contents.

Doubtless these various methods have been suggested by the difficulties encountered in the individual cases in bringing up a contracted stomach into the abdominal wound and there fixing it, and at the same time attaining the objects above mentioned.

The scope of this paper will not permit a detailed account of the various methods that have been proposed and practiced.

Bickham has given a comparison of these methods that may enable the surgeon to select such as may suit individual cases.

The Ssabanajew-Frank method performed through the separate fibres of the rectus muscle is probably the best for a permanent fistula especially in a lax stomach.

Kader's method is probably best for small or adherent stomachs.

Marwedel's method is probably the best for the rapidity of healing of the fistula and Howese's method is probably most quickly done.

The operation performed in case reported below was that known as the Ssabanajew-Frank. So called because it was done in 1890 by Ssabanajew, of Odessa, and by Frank, in Vienna, in 1892.

The case is taken from the case book of the city hospital.

B. B., colored, male, aged 21, farmer, was admitted to the hospital Nov. 12th, 1904, during my service, with the following history:

He lived in the country, he said, and that his health had been good since childhood, except for chills and fever occasionally.

During the first week of January, 1904, he was given a drink of whiskey containing concentrated lye, which he drank. This was followed by intense pain in the stomach and nausea, but he was unable to secure the aid of a physician until the

third day after taking the dose mentioned.

When the physician reached him he was suffering with intense pain in the mouth, throat and stomach.

Vomiting was almost constant, the vomited matter being blood stained.

The abdomen was somewhat distended and tender on pressure; fever was high and the pulse weak and rapid. No examination was made of the urine for blood or albumen.

The case was discharged after the third visit. Nothing more was seen of the case until July 15th, when he came to the Dispensary Office very much emaciated and with a partial esophagal stricture.

An attempt was made to dilate the stricture but this was unsuccessful.

The patient was therefore sent to the City Hospital in Charleston, where he was admitted on July 24th, 1904.

He was nourished for a few days by nutrient enemata. On July 29th a gastrostomy by the Ssabahajew-Frank method was done by the surgeon in charge of the hospital.

The incision in the operation was made a little low and there was some doubt whether the stomach or intestine was attached to the abdomnial wound.

A rubber tube was left in the opening through which the patient was fed for two weeks. Bougies were passed and the oesophagus dilated at the time.

The abdominal wound was allowed to close and he was discharged on Oct. 1st, 1904.

He was able to swallow and increased a good deal in weight. After his discharge he failed to pass the bougies and as a result the stricture of the oesophagus again contracted.

On November 12th, 1904, he was admitted to the hospital for the second time, and came under my care.

He was emaciated to an extreme.

"The emaciation, the prominent or almost uncovered muscles and bones, the expression of anxiety and suffering, the furrowed forehead, the sunken eyes, the open, sharply defined nostrils, the long, compressed lips, the depressed angles of the mouth and the deep curving around these angles, denoted the sufferings of slow but certain starvation.

His exhausted, weak condition seemed almost to preclude the performance of an operation, and he was given nutrient enemata, together with other treatment calculated, it was hoped, to improve his general condition. Efforts to pass bougies through the oesophageal stricture proved unavailing.

On Nov. 17th, the operation for gastrostomy was done according to the Ssabanajew-Frank method.

The primary incision was made obliquely, three inches in length over the outer third of the left rectus muscle, beginning near the median line and passing downwards and outwards, somewhat more vertically than previously, though approximately parallel with and about one and a half inches from the left Costal arch. The vessels were clamped and the edges of the wound retracted.

The rectus muscle being thus exposed the anterior layer of its sheath was wider. The fibres of the outer part of the muscle were separated longitudinally by blunt dissection down to the posterior layer of the sheath, the transversalis fascia, subperitoneal areolar tissue and the peritoneum were successfully divided to the extent of the wound in the skin—preserving as much as possible the muscles and nerves. These structures were retracted as they were divided.

The abdominal cavity having thus been opened, two fingers were introduced and the stomach sought for. No difficulty was experienced in this procedure as the stomach was easily recognized by the touch.

A long cone of the anterior wall of the stomach was drawn through the abdominal wound by means of a silk traction ligature passing through the serous and muscular coats, the apex of the cone being represented by a part of the stomach wall nearer the greater than the lesser curvature and nearer the cardiac than the phyloric end.

Sufficient length of the cone was drawn out to pass without tension under a bridge work of skin about two inches wide.

The second coat of the stomach forming the base of the cone was now sutured

to the peritoneal and fascial edges of the wound with fine silk sutures.

The serous and muscular coats were then attached throughout to the posterior sheath of the rectus by a second tie of fine silk sutures, the danger of constriction being avoided.

A secondary incision three fourths of an inch in length was now made through the skin and fascia about one inch above the costal cartilage and approximately parallel with the first incision.

These incisions passed only into the connective tissue plane.

By blunt dissection from the larger to the smaller wound, the two were connected and the intervening bridge work of skin thus undermined along the fascial plane.

A pair of forceps passed through the smaller opening into the larger grasped the silk ligature and by this means the cone or the stomach was drawn into the smaller upper wound, over the edge of the lower costal cartilages, where it was held in place by silk sutures.

These sutures were passed through all the coats of the stomach on one side and through the skin and fascia on the other.

The small incision was sutured at either end, leaving a sufficient opening in the center for the passage of the cone.

The separated edges of the rectus and its sheath were now sutured with interrupted chromic cat gut from either end toward the center, leaving a sufficient opening to guard against dangerous constriction of the base of the cone, while at the same time approaching the base nearly enough to form a muscular circle about it.

The skin wound was closed with interrupted silk worm gut sutures. This having been accomplished, the apex of the cone was cut off, the mucous membrane everted and stitched to the serous coat.

A portion of stomach tube was then passed through the fistulous track, thus established into the stomach.

The patient lost but very little blood during the operation.

Before he was removed from the table an enteroclycis was administered, composed of a pint and half of normal salt solution, an ounce of whiskey and thirty drops of a 1 to 100 solution of Adrenalin Chloride. This was repeated at intervals of three hours until he recovered from the shock of the operation.

As soon as he had recovered from the effects of the anaesthetic, feeding through the tube was commenced, but as no food had been received into the stomach for a long time nourishment was given cautiously and in small quantity. The nourishment consisted of beef tea, yolk of egg and milk.

The stomach tube was kept continuously in place for one week, after this time it was removed tentatively, but had to be replaced because of leakage of gastric juice and regurgitation of food.

The wounds healed well and it was found that the tube could be removed without being followed by leakage.

From this time the tube was introduced only at regular intervals for the purpose of feeding. As he progressed towards recovery he masticated his food before it was introduced into the stomach.

The stricture of the oesophagus was dilated from day to day with bougies until he was discharged, Jan. 15th, 1905. He could swallow and had increased in weight at this time. He was instructed to pass a bougie himself, but the gastric fistula was not closed lest there should be a recurrence of a tight contraction of the esophagus as on the previous occasion.

In the study of this subject I am indebted to the articles of Bickman, Jacobsen, Wyeth and Dennis.

DISCUSSION.

MR. MONSEN:—I would like to have the doctor state if he experienced any difficulty in passing any bougies up the esophagus, and how that operation was done so as to be successful?

DR. H. A. ROYSTER, of Raleigh, N. C.:—I hesitate to discuss each paper as it comes up, but I am interested in so many I cannot refrain, and especially as Dr. Simons has asked me to say something I feel constrained to do so.

My experience is limited to one case, with a child two years old, who had a traumatic stricture of the esophagus, produced by concentrated lye, and the case being seen by me two months after the occurrence. The child presented a typical case of starvation, so graphically described by Dr. Simons. I did an operation according to the Coder method, making a straight incision through the left rectus, bringing the stomach up, and putting sutures in one, then the other,

outlining the space through which it is necessary to introduce the tube. These sutures were held up as described, and an incision made into the stomach sufficient to admit the tube, the tube placed in position and these purse strings tautened, the first holding in the stomach, this way, and the second folding in still more, thus holding the tube in position. Silk-worm gut sutures were then passed through and through the abdominal incision, taking up a portion of the stomach wall in their grasp in order to hold the position. The result of the case was unfortunate. because the child died next morning, from the result of the wasting away and the shock of the operation.

I did not succeed in introducing any bougies into the esophagus. I had great difficulty, so much so that I felt that the operation was prolonged unduly and let that go until a later period, the child not being able to stand a very prolonged operation.

The results of this operation if done early are always good, but if done late are nearly always bad.

To show how some men regard these strictures of the esophagus. This case was kept under the care of a physician in the country, who stated to the family that this stricture could be dilated by giving food to the patient, and he kept it under advisement, without introducing any instrument at all, saying the food would help to dilate the stricture. That only shows how these cases are delayed in the hands of practitioners frequently until referred too late to the surgeon.

DR. PATTERSON:—I have had a good deal of experience with stricture of the esophagus from the same cause, concentrated lye, and I think it would be a good idea for the medical Association to attempt to have some laws inaugurated preventing the indiscriminate use of concentrated lye. It is certainly the cause of more accidents than almost any drug we have.

The treament I have resorted to was gradual dilation with whalebone bougies. My experience is that food produces an impaction, and we have a total occlusion, and when it gets in that condition the only remedy is forcible dilatation, with a whalebone bougie. I have been able to relieve all these patients except, I think, two. I have treated 7 or 8. I reported some cases several years ago at one of our meetings.

DR. SIMONS:—In reply, I would thank Dr. Patterson and Dr. Royster for speaking to my paper.

In regard to Dr. Monsen's request, I would say that the bougie should be passed daily, and if the bougie is neglected the stricture will recontract. Precisely parallel conditions as stricture of the urethra, treated by dilatation. It is a trite old saying, "Once a stricture, always a stricture." If treated by dilatation only it will continue, unless treated from day to day. In this case that I discharged, if the boy fails to pass the bougie daily, as he was taught in the hospital,—if he passes that bougie every day he will be able to swallow. He could swallow before he left the hospital. I kept the stricture open because of the experience I had with the first operation, where the stricture was allowed to close from lack of attention.

As to the method of operation. I selected the Ssabanajew-Frank method. Dr. Royster did Coder's method.

I was prepared, when I went into the operating room for that case. to take Coder's method. The advantage in that is it is unnecessary to pull the stomach out of the abdomen to any extent, because the tube is imbedded in the wall of the stomach whilst it is well down in the abdominal cavity. For that reason Coder's method is particularly applicable to this case, in which the stomach was contracted and the surgeon unable to get the stomach out. But, when I got into the operating room, the house surgeon said to me, "You will have trouble; the stomach is so contracted you can't get into the wound." I was prepared to do Coder's, or some other operation suitable to a contracted stomach, but when I got there and inspected the abdomen of the man I found a previous incision had been made a little above the umbillicus and transverse to the rectus, and I was satisfied that what the house surgeon told me was correct, and that it was not the stomach, but that a portion of the intestines had been sewn. I concluded that Ssabanajew-Frank's operation was an ideal operation,—and the result proved that was correct. Making an incision higher up, I put in my finger, and I could tell by the feel of it that I had the stomach, and I had no difficulty in getting out just as much as I wanted to get the cone necessary for the performance of the Ssabanajew-Frank operation.

As to Dr. Patterson's remarks, I am glad he made them, because you will find that this concentrated lye is put up in cans, and so many little fellows drink it, thinking they have a can containing condensed milk. I have been teaching all of my patients the danger arising from these accidents, and asking them not to permit concentrated lye to be introduced into the house. I think the influence of this Association should be used, as he suggests, to try and have such legislation passed, as to the form, at least, in which it is put up, that it will be distinct, and the little ones will not mistake it for something else when it is in the house.

A PLEA FOR STATE SANATORIA FOR TUBERCULOUS PATIENTS.

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The universal fight that is now being made throughout this country against tuberculosis proves that the medical profession and the educated layman has at last realized that prevention plays as important a role as attempted cure. This disease, so widespread, and so far-reaching in its disastrous results, is undeniably curable when taken in hand early, and undeniably preventable. As medical men, we know that nature is the only source from which we can expect a cure. We have not yet discovered a specific, nor have we discovered immunizing agent, but we have discovered that if we are able to increase individual nutrition, to place the patient in a pure atmosphere and to educate him in the hygienic laws of life that

the majority of cases taken in hand early recover. We have also discovered that the disease is infectious, and that the infection being transmitted through the expectoration, is preventable; that inheritance is but a small factor in the production of tuberculosis, and were it possible to control every case the dread White Plague could be stamped out.

We have learned then, first, that tuberculosis is almost universal, and that a large majority of individuals over thirty years of age have some focus, latent or active, in some part of his body.

Second, that tuberculosis is infectious and communicable, and being infectious, is preventable.

Third, that as the majority of cases of tuberculosis get well, the disease is curable.

Fourth, that sufferers from pulmonary tuberculosis recover without change of climate, and that although climate is a factor in treatment it does not play the essential part it was once believed to do.

Fifth, that unhygienic surroundings, bad air, improper food, filthy habits, excesses in vice, over-crowding, etc., all tend towards the development and rapid progress of tuberculosis to a fatal termination.

Let us consider these facts seriously. The universality of the disease is not sufficiently recognized by our practitioners of medicine, and in consequence many cases progress to a stage too late for arrest, because the individual and his doctor are unsuspicious of the cause of the ailment. Early recognition of tuberculosis is essential if we expect to cure. Once lung tissue has been destroyed *en mass* and secondary infection with other germs has occurred the permanent cure is almost hopeless. How often do we hear people assert that because there has been no tuberculosis in their family, and no inheritance, that it is impossible for the symptoms they present to be tuberculosis. How often is the weak anaemic adolescent with dyspeptic symtoms and a slight cough doctored by the poly-pharmacist for months in the end to discover that he has an area of tubercular infiltration in the lung which has never been examined, and just here let me make a plea for the more frequent and careful examination of the lungs. Physical diagnosis is extremely difficult, and our ears and eyes become trained only by constant practice. Slight changes in physical signs have to be carefully hunted for and recognized when found. Gross lesions that are manifest show themselves when too late to do good by treatment. How many of us neglect the thorough exploration of the chest and how few of us are able to recognize early and slight changes. How seldom do we conscientiously search for the tubercle bacillus in the sputum, whose presence clears up the doubtful diagnosis and makes the chain of vague symptoms point to the pathological lesion and cause. We must remember that we often discover the lesions in individuals who look "the picture of health," rosy-cheeked, stout, well-built people, often make us unsuspicious of the cause of their symptoms by their healthy appearance, and we are as apt to find the tubercular germ taking root and flourishing in the muscular athlete as in the anaemic school-girl. Upon the early recognition of the tubercular cause will depend our success in a cure or arrest of the process, and I again urge the neccessity and value of more complete and thorough examination of every case that comes up for diagnosis.

That the disease is infectious and therefore preventable needs now no argument. The bacilli thrown off in the expectoration become dried dust and finds entrance through the respiratory tract of the exposed. Of late years this has become so well known that laws and ordinances are passed in every city making the act of spitting in public places an offense punishable by fine. But this is not enough. Patients themselves must be taught and made to understand the danger in their sputum. If the sanatoria established throughout this country have done no other good than to have taught their inmates to collect and destroy their expectoration they have accomplished a great point in preventative medicine. This is a point that we can not pass lightly. We must all do missionary work in this direction amongst our patients, especially those of the poorer and uneducated

classes. How little precaution is taken and how lightly the infectious nature of the disease is regarded is only too evident, and even in our hospitals, asylums and poor houses, directly under the care of medical men, the utter lack of precaution or careless attention to these matters is evident. We must awake to the realization of the danger from infection in tuberculosis, and the first step in the crusade against this disease, that claims its victims in such large numbers yearly in our midst, is to preach the fact that the expectoration is the cause of the spread of the germs, and to teach them how to destroy it and how not to contaminate their household and family, their friends and the general public.

As to the curability of incipient tuberculosis there is now no question. The records and statements of the Sanatoria throughout this country and Europe prove conclusively that the majority of early cases properly cared for get well. The Massachusetts State institution, at Rutland, claims 75% of cures in incipient cases during the last year, and every institution is yearly adding to its per cent. of cures. The treatment is extremely simple and the very nature of its simplicity renders it difficult of execution. Fresh air and outdoor life, with limited exercise and wholesome food; achieving the greatest amount of bodily nutrition whilst breathing a pure air are the only essential requisites. I have said that climate is not an important factor. It is only necessary that the air should be pure and not too damp, and that we should have a maximum of sunshine. To obtain these essentials it is only required that our consumptive leave the sea-coast and go into some country district removed from the crowding of cities and the vitiated atmosphere of factories and manufacturing towns. Having obtained this, the next step is the outdoor life. This should not be done in a vague, carnal way, but with regularity —the patient spending 15 to 20 hours out of the 24 in the open air. To accomplish this it is necessary that he sleep out of doors, for no matter how well ventilated a room may be or how many open windows furnish the air, experience has taught that they do not do as well as when sleeping on an open porch or veranda. No matter what the weather or temperature, a tuberculous case can be taught to sleep out of doors and in a few weeks they themselves realize the benefits so thoroughly that they prefer it. The methods employed at the different sanatoriums and tuberculosis hospitals throughout the country is extremely interesting, and their magnificent results more than encouraging. At the Adirondack Cottage Sanatorium at Saranac Lake, N. Y., founded by the pioneer of the outdoor treatment of tuberculosis, Dr. Ed. L. Trudeau, the plan is to have cottages with four rooms surrounded by broad verandas. The door of each room opens on the veranda and is wide enough to permit the bed being rolled out and in. Each patient gets up at 7 a. m., has a cold shower bath or cold sponge as they prefer, dress and walk to a central building to breakfast. From breakfast until 11 a. m. he is out of doors, reading, playing games or carrying on any light occupation. From dinner until supper, 6 p. m., he is still out sitting on the veranda or strolling through the grounds. From 6 until 9:30 he is allowed to remain indoors. At 9:30 he prepares for bed; the bed is rolled out on the veranda, where he sleeps until morning. Now this is a very simple proposition in summer, but think of carrying out this routine through the winter, with the thermometer ranging from 20° below zero to 20° above in the 24 hours. The heavy snow fall makes walking out of the question and the intense cold interferes with usual pastimes; consequently these patients sit wrapped in furs and rugs for hours at a time using every method they can devise to keep warm. The beds are rolled into the warm rooms during the day so that they do not become chilled, and at the last moment before the lights are turned out they are rolled out on the veranda, the patients sleeping out of doors in this intense cold. The effect is marvellous; they become red cheeked and healthy looking, put on flesh, develop an appetite, feel well and cheerful, and soon see for themselves the benefits of what at first appears to them a cruel and

dangerous mode of life. At the Loomis Sanatorium Annex (where I have just passed the winter) they use lean-tos instead of cottages. They are cheap, easily taken care of, and give excellent results. A small central room which is well ventilated and heated, contains sixteen lockers or small closets, two tables and water basins, water closets, etc; from this central room a long veranda runs on each side capable of holding each eight beds. It is plainly built, covered with a shingle roof and enclosed at the back, the front being open; their width is sufficient to admit of a lounging or steamer chair to be placed at the foot of each bed. Here the patients sit during the day and sleep during the night, heavy canvas curtains on rollers in front of each bed protecting them somewhat from drifting snow and rain. I have often seen the beds covered with snow during the night, and each bed is provided with a rubber sheet to prevent the bed clothes from becoming damp. Patients are allowed to wear all the clothes they desire, and use any method that may suggest itself to them to keep warm at all times, only they are not allowed indoors between 7 a. m. and 5 p. m. except for meals.

In all these institutions great care is paid to the food and cooking. Milk and eggs are furnished freely and every one encouraged to drink milk between meals. Careful physical examinations of each case are made monthly and notes of each case kept. Weight, temperature and pulse are carefully recorded, and a minute history of the case is kept. The laboratory examinations of urine, sputum, etc., are made each month and a blood examination on admission and discharge. When cases develop some complications, as a hemorrhage for instance, there are rooms in the main building used as an infirmary, or in the larger institutions a thoroughly equipped small hospital is a part of the institution. The curative process in tuberculosis is necessarily slow and covers a period of years in many cases. The length of stay in the institution of course varies usually from six months to one year. During this period the general conditions of the individual is greatly benefited, but this is only a small part of the good accomplished; he is taught how to live and how to take care of himself, and he is taught how each case is a specific focus of infection and how he must avoid conveying the disease to others. When the whole civilized world is educated up to this point we will find tuberculosis decrease the number of its victims each year and finally this widespread infection may be stamped out. Why is not the care and treatment of tuberculous patients taken up and managed by the State Governments? Gradually the different States in the union are beginning to see this matter from the right standpoint and building and maintaining their institutions. They will care for and battle with yellow fever and small pox patients when these diseases kill only an infinitesimal number compared with tuberculosis, and yet they allow this infection to exist broadcast and take no steps towards its prevention and cure. As the disease is met with most often in the poor, badly fed and uneducated, it behooves the authorities to look into the methods of life of these people and when the disease is found amongst them they should be removed and cared for. Numbers of the State institutions are run on a semi-charitable basis. Patients are charged on the average of $5.00 a week in most of them, and the State supplies the deficiency. With an appropriation for the original plant and a small charge for each patient, the annual expenses need be small.

The State of South Carolina is provided by nature with a climate peculiarly adapted to the treatment of tuberculosis. The short, mild winter would make the cost of a State institution much less than those of the Northern and Western States. The death rate from this disease is enormous in our State and on the increase. I have not been able to procure the figures for the State, but in the City of Charleston I find that in 1903, 217 persons died of tuberculosis or 3.87 per 1,000 of population, and that in the decade ending 1903, 2,590 deaths are recorded from this disease. Now if this Association could memorialize the legislature and get

them to appropriate a sum for an institution, and run it on approved methods, economically and efficiently, they would be able to save many valuable lives and at the same time, by removing foci of infection from populous districts, so diminish the spread of the disease. Elaborate institutions are not necessary. The plan of lean-tos at the Annex of the Loomis Sanatorium are cheap and perfectly efficient. There is no need here in this sketchy outline to go into figures of expenses, but suffice it to say that these buildings can be erected at a cost of about $100 per patient. Of course this is exclusive of executive buildings, furnishings, site, etc., but in our mild climate the outdoor life could be thoroughly carried out and at the same time light and useful employment given patients, which would reduce the cost of living, such as growing the necessary vegetables for the table, raising poultry and eggs, running a model dairy farm, etc., all of which are perfectly feasible in conjunction with a State sanatorium for tuberculosis. This paper is a mere suggestion to the State Association to consider the matter and discuss its practicability; and having lived and worked in two of the best known institutions in this country for the past year, I have become impressed with the importance of the war against the Great White Plague and its management and control through institutions and sanatoriums.

CLINICAL PRESENTATION: A CASE OF COMPLETE DOUBLE CONGENITAL CAPSULAR CATARACT.

J. W. JERVEY, M. D., GREENVILLE, S. C.

Professor Herman Knapp relates the following incident which occurred during the incumbency of his Heidelberg clinic:

"A poor widow brought to me her twelve year old daughter, who, she said, had never had any inflammation or disease of her eyes, but was born blind. I found both pupils narrow and closed by a pseudo-membrane. One eye showed signs of irido-choroiditis, was shrunken, and totally blind. The other, however, was well formed and had good perception of light. My diagnosis was congenital blindness from foetal irido-choroiditis. I admitted her to the clinic, and on one eye made an iridectomy which gave her good sight. The case was presented and analyzed before the students as remarkable and important in its embryological and practical aspects. She left the hospital in a week.

"Two weeks later the secular press was full of high-colored accounts of the 'wonderful restoration of sight in a blind-born twelve-year-old girl by the Holy Virgin of Walldurn,' the Lourdes of the Catholic portion of the Grand Duchy of Baden. The wonder was attested by the priest, the physician, and the mayor of the place, and by a Spanish Count. The incident was true, the story went, and the wonder so much the greater as the child had been admitted to the Eye Clinic at the University of Heidelberg and after short treatment discharged as incurable. As soon as I had read the story I informed the priest of the facts. The report had been so widely circulated that a high official of the government sent me a letter of inquiry in regard to what I knew about the case. I answered that I had written to the priest at once, but had not received a reply. I had abstained from a public refutation because I believed the priest to be a benevolent, honest man, for he had sent to the University Clinic many eye patients that had gone to Walldurn. The government official wrote me back: 'You will receive your justification, but you will have to wait two weeks. The place requires a wonder every few years to keep up its reputation.' So it was. The priest thanked me that I had undeceived them, and in excuse for the delay of his answer he said the child had been presented to them as congenitally blind, and had behaved so, but after she had been led to the church several times, and then held over the altar of the Holy Virgin, she had exclaimed, 'I see, I see!' In order to explain the undeniable fact of the child's sight they had written to the mayor of

the birthplace of the child, and had not received an early reply."

I have had the good fortune to see a case here, that is in some respects similar. This small boy, whom I present to you for inspection, was brought to my office last summer. He is 12 years old, and for the past two years has been at the Cedar Springs Institute, the State Institution for the Deaf, Dumb and Blind. The only vision he had was that in the right eye. He could distinguish brilliant colors if brought within an inch or two of his face. Merely a little corner of the pupillary opening permitted any vision at all—at best only a fleeting glance—and of course he had no practical sight. I found he had double congenital capsular cataract, and advised operation. Owing to the fact that he had not seen during his lifetime, the eye-balls, as you will observe, are very small, have never been fully developed—although this is partially hereditary, other members of the family, the mother markedly, having small eye-balls. From the fact that he has never seen, he has no coordination of the ocular musculature; he cannot fix his eyes on anything; sees more than he knows he sees; does not realize what he does see; in fact, he will put out his hand now, thinking he can touch something that may be 20 feet off. With a plus 9 spherical lens over each eye he has now an actual vision of about $^{10}/_{100}$. That is perfectly practical sight for entering any one of the coarser trades. Of course he could not do any work that requires close application of the eyes, but he is at least so much better that he can follow any of the coarse arts or trades with perfect satisfaction. The case is more or less pathetic, as he is the only boy in a family of five.

The operation I did was extremely simple, requiring no skill particularly. Almost anybody could put a needle into the eye and break up the capsule, although it is almost always necessary to repeat the operation.

In this case I operated first on the right eye. I thought it wise to go slowly and cautiously. The capsule was thick, tough, and leathery, and I found in a few weeks that I had to repeat the operation. I repeated it on the right eye, a simple discission, three times, and I have not especially good results in that eye. The capsule is too tough; it breaks up, but owing to the elasticity of the fibres it has a tendency to draw, and I cannot cut it across the fibres. I am going to complete the operation by making a linear incision along the cornea and snipping off that capsule with scissors.

The left eye I operated on about two weeks ago. Having gained a certain amount of vision in the right eye, I considered I could justifiably do more radical work in the left without waiting for the slow process. He is a very nervous child. I performed the operation with chloroform anaesthesia, making the usual corneal incision, hooked the pupillary margin with a blunt hook, drew it out and made the iridectomy, and then, with forceps, grasped the capsule, drew it out and excised it. This eye, as you will observe, is by far the best of the two, though only operated on two weeks ago, and only once. He has now good practical vision, and in time he will learn to appreciate distances and get good judgment of projection. I am inclined to think, too, that more or less muscular correlation of the two eyes will become established later.

(Case presented and examined by members.)

DR. HORLBECK: This is a very interesting subject to any man who has done eye work. I have looked at the case, and think the doctor is to be congratulated on it. As the doctor says, it is not a difficult operation, but it is one that is very delicate, and requires a good deal of judgment. Unfortunately, there are a great many of such cases around. Since I have been practicing in Columbia I have been fortunate enough to see two such cases, but for religious reasons they refused operation, thinking the affliction was put there by The Almighty and ought to stay there.

These operations require a great deal of judgment in regard to time to operate, and, after the incision is made, in watching the eye in regard to tension. Dr. Jervey says that the tension was not increased in the eye after operation,—I presume, due, as he says, to almost complete absence of lens matter in each eye,—a slight amount of degenerated lens matter in each. I think the more suitable operation was done on the left eye, taking out the capsule, because undoubtedly the trouble with the other eye was a thickening of the lens capsule itself.

DR. PORCHER: I want to offer the doctor my congratulations; first, on his pluck in attempting to

remove such a condition as that, and next on his success in doing it. I think the man who operates on a case like that. with his reputation at stake, deserves the thanks of the Association for undertaking it.

DR. MONSEN: I congratulate the doctor on his success, and thank him for the initiation in undertaking the work. It will move some of us to do more careful work and not think that the large operations are the most essential.

DR. JERVEY: I thank you, gentlemen, for your very kind reception of the case, and for the privilege of presenting it.

ANEURISMS OF THE GROIN.

Report of a Case.

A. J. BUIST, M. D., CHARLESTON, S. C.

The infrequency with which we see aneurisms of the groin and the comparitively high per cent. of failures observed in their treatment are my excuses for this report of a case operated upon in December, 1904.

The case was that of a negro, age 43, occupation wagon-driver, who entered the City Hospital, Charleston, S. C., December 23rd, 1904, suffering from intense pain in the left groin, numbness of the inner side of the thigh and inability to walk or stand. A tumor about the size of a hickory nut had been noticed first by the patient in August, 1904, just beneath Poupart's ligament. Its growth had been slow but continuous. Upon examination there was found in the upper portion of Scarper's triangle and extending upward and beneath Poupart's ligament a pulsating tumor, globular in shape and about the size of the fist. The pulsation was expansive and there was present a thrill and bruit. The skin over the tumor was tense, glazed and hot and upon palpation deep seated fluctuation was felt. The patient's pulse was 126 and temperature 99 3-5. A diagnosis of aneurism of of the common femoral and lower portion of the external iliac arteries accompanied by inflammation of the sac and perivascular tissues was made.

Because of the thinness of the coverings of the tumor all other forms of treatment were inadvisable and operation was suggested and performed Dec. 29th. As it was uncertain how far up the external iliac artery the disease extended the extraperitoneal method of ligating that vessel was deemed inadvisable and the transperitoneal method of operation employed. The bladder and rectum having been thoroughly emptied just prior to operation, the abdomen was opened by a median incision, the patient placed in the Trendelenburg position, the intestines held back by pads and the bladder held well forward. In this way the iliac vessels can be easily examined by the eye and finger and the height to which the disease extends can be readily observed. It was seen that but the lower portion of the vessel was involved and that a ligature could be easily and safely applied to the middle portion of the vessel at the most desirable point. An incision three-quarters of an inch in length was made in the peritoneum overlying the vessel, the artery separated from the vein and a No. 2 cromicised cat gut ligature used for ligation. The peritoneum was now brought together over the vessel and the abdominal cavity closed in the usual way. Examination of the aneurismal tumor now showed that it was slightly smaller, and that pulsation and bruit had ceased. The limb was wrapped in cotton, elevated and artificial heat applied for a few days. The temperature remained above normal for several days and the pulse rapid for about two weeks, but the pain in the groin rapidly disappeared. The collateral circulation was quickly established, the nutrition of the limb never being threatened. The tumor continued to diminish in size, the patient got out of bed on the twenty-first day after the operation and left the hospital on January 27th. He was seen in the latter part of March, at which time he complained only of a sensation of numbness over the inner portion of the thigh.

He was again back at work in the capacity of a porter. The tumor at that time was hard, non-pulsating and about one-fourth its original size.

From a perusal of even the most recent works upon surgery we are left somewhat in doubt as to the best method of treating aneurisms of the larger vessels. The

statistics found therein would lead us to believe that the mortality and failures resultant upon ligation of the external iliac artery for aneurism of the groin are high. These statistics were, however, for the most part, compiled prior to the attainment of the perfect asepsis that we have in operation to-day.

Delbet's Statistics, published in 1889, comprising the results of sixty-seven cases in which the external iliac was ligated for aneurism of the groin show 42 cures and 25 failures, 13 of the failures resulting in death, a mortality of 16.9 per cent. Kirmission's group of 40 cases reported in 1884, show a mortality of 12.5 per cent. As late as 1898 Morton collected 29 cases of aneurism involving the iliac artery, in all of which ligation by the transperitoneal method was adopted, in which there were 22 recoveries and 7 deaths. A number of individual cases reported since that time, however, seems to indicate that the mortality is much less.

Dennis, in 1886, was the first to suggest the transperitoneal method of ligating the common or external iliac artery for all aneurisms of the groin. This is undoubtedly the simpler and safer operation, especially if the tumor seems to extend above Poupart's ligament. There are many advantages which it has over the extraperitoneal method. In the first place, it is the easier of the two operations. All that is necessary is to see that the rectum and bladder are thoroughly emptied just prior to the operation, and that by means of the Trendelenburg position and pads, the intestines are held out of the way.

By these procedures the pelvic cavity is rendered practically empty, both the external and common iliac arteries can be examined by means of the eye and finger, the extent to which the disease extends up the artery noted and the ligature can be applied in the most advantageous position. There is little or no damage done to the cellular tissue surrounding the iliac vein. The position of the ureter must be remembered and care taken that it is not included in the ligature. The extraperitoneal operation is much more difficult. In its performance we are more than apt to injure the deep epigastric and deep circumflex arteries, the integrity of which it is important to preserve. The spermatic vessels, the ureter, if it crosses the artery low down, the genital branch of the genitocrural nerve, the spermatic cord and in the female the ovarian vessels must also be avoided. Pelvic cellulitis and peritonitis have not infrequently followed the more or less rough handling of the subperitoneal tissue in the attempt to shove the peritoneum upward and out of the way. Again, the handling and damage done to the sheath of and cellular tissue surrounding the iliac vessels is much greater than in the transperitoneal operation, a fact that increases the possibility of a phlebitis of the iliac vein with its resultant interferance with the return circulation from the limb

The chief dangers incident to the operation are secondary hemorrhage and gangrene. The first is best avoided by strict asepsis, it being rarely seen if the operation is a clean one. Gangrene may be due to too slow development of the collateral circulation or to the occurrence of an iliac phlebitis. The importance of preserving the deep epigastric and deep circumflex iliac vessels is apparent. Not only do they assist materially in maintaining the circulation in the limb, but because of their allowing a certain amount of blood to flow through the iliac and femoral arteries below the ligature there is enhanced the formation of an active clot in the aneurism which upon becoming organized perfects a cure. The cutting of these vessels at the time of ligating the iliac artery occasions the formation of a passive or soft clot which may excite inflammation and suppuration in the sac with subsequent rupture. Circulation in the limb should be encouraged by elevation, wrapping with cotton and the judicious application of artificial heat.

Phlebitis is best avoided by the use of a non-irritating absorbable ligature and little interference with the vein and its cellular sheath.

Among the subsequent and lesser evils resulting from the operation are permanent deterioration of the nutrition of the

limb, loss of nerve or muscular power, and persistent and recurrent ulceration of the skin.

The question of incision or excision of the sac and contents necessarily arises in these cases. The results following those cases in which it has been done lead us to believe it is not the best operation. At any rate nothing is gained by excision at the time of ligating the iliac and much may be lost as the chances of gangrene are increased and there is danger of injury of the femoral vein. Subsequently if suppuration in the sac takes place or pulsation in the tumor recurs and is persistent, excision may be done with ligation of the vessels entering the sac. By this time the collateral circulation has had time to become better established.

Other methods of treatment of aneurisms in this locality have been attempted, such as galvano-puncture, compression, forced flexion of the limb on the body and the injection of coagulating substances but they have with few exceptions resulted in failure. Spontaneous cure of aneurism of the groin is very rare and the best chances of success seem to follow ligation of the external iliac by the transperitoneal method.

DISCUSSION.

DR. M. SIMONS: This is too valuable a contribution to allow it to pass without discussion, and I would ask Dr. Royster to speak on the subject. I am interested in the case, because I saw it with Dr. Buist. He got a brilliant result, and it was altogether a brilliant operation. The ease with which that artery was tied was something that is very attractive. To a man familiar with abdominal work, and who knows how to get into the abdominal cavity, the ligation of that artery was easy, and when the doctor got through with it, the wound, was scarcely appreciable. I was particularly interested. I had had a similar case, and had never seen an artery tied in that way. I did a much more difficult operation, taking out the whole sac,—a very desperate operation,—and was anxious to see what this operation would produce, it gave me great pleasure to see the ease and skill with which it was done.

DR. ROYSTER: I feel very much as if I shall need Dr. Porcher's treatment before I get through, and I should not have thought of rising to speak on this subject except having been asked to do so.

I think this is one of the best papers I have heard at this meeting, for two reasons: first, it shows what can be done by proper diagnosis and treatment, and second, by a proper description of it after it is done. It is very seldom that a man can do both equally well. I think the doctor is to be congratulated on his handling of the case.

The diagnosis for aneurism is usually easy; sometimes it fails. I knew a country doctor in my State some years ago, a very brilliant surgeon, who was a loss to the surgical science because he did not report any of his cases. He said he was driving along a road one evening, with his eyes shut, when a man jumped out of the woods and hailed him, and said, "Doctor, I have a little tumor, or a little rising in my knee; I wish you would cut it." The doctor said all right, and put his lance into it, and the blood spurted. He said that he took him to a nearby branch and got a flat stone and bound it on the wound with a strip from his shirt, and carried him home. "And," he said to me, "do you know, that darned fellow got well."

Dr. Buist's paper shows they can not only get well under those circumstances, but it is best to give them a chance in the right way, making the diagnosis and the operation in the right way.

I have had three cases, with good results.

One had a disturbance of the skin, and another disturbance of circulation, owing to the fact that the patient had tertiary syphilis. and these manifestations continued for some months.

This operation which the doctor did was just the right thing, done in the right way, and the result is sure to be right. I agree with him entirely in his ideas of excision of the sac, and his reasons for not excising it were stated perfectly. It makes an otherwise easy operation dangerous and difficult,—I say easy, when planned properly,—it adds to the danger and does nothing to help the result. He had confidence in himself, and faith that he was doing the right thing. I think these operations ought all to be reported and discussed.

DR. BUIST: I thank the gentlemen for the remarks made concerning the paper. There is nothing more I can add to it.

I have on three occasions tied the femoral artery, but this was my first experience with the external iliac. I tied one for aneurism in the femoral lower down, in which there was a recovery. I tied the artery again, in a case Dr. Whaley operated on for some trouble in the popliteal space, whether an aneurism I do not know. The man had a secondary hemorrhage. Dr. Whaley had turned the case over to me then, and I ligated the femoral in its lower portion.

That man recovered. I ligated the artery the third time for gun-shot wound in the artery. In all three cases there was no evidence of any interference with the circulation.

SUPPURATING APPENDICITIS.

BY F. L. POTTS, SPARTANBURG, S. C.

Mr. President and Gentlemen:—

I have chosen for the subject of this paper "Suppurating Appendicitis,"—a subject I know that is well worn, but one still interesting and most important, and

I may also add, a condition that should be prevented to a greater extent than at present. I claim no originality whatever in presenting to you a few well established facts, facts that are worth much, facts if well taken and heeded will save a great many precious lives, lives that are being lost by the so-called medical treatment instituted at the beginning and kept up two, three or four days, before surgical interference is thought of; this I claim is the cause of our mortality in appendicitis, in as much as it is the cause of suppurating appendicitis. Appendicitis is pre-eminently the disease attended with pain and tenderness in the right illiac fossa. Whatever the immediate cause, whether it be a quickly acting one, or, as is most common, has been silently working, the attack itself is generally sudden, and announces itself by acute abdominal pains, by tenderness in the right illiac fossa, by nausea and vomiting. The pain and tenderness are very significant. Although a continuously improving technique has within the last few years considerably reduced the mortality after operations for appendicitis, the problem of successfully coping with suppurative and infected cases is still far from being solved. The vigorous stand taken by most operators in favor of early operation has borne fruit. The doctrine that the best results in all cases may be obtained by an operation as soon as the diagnosis is made, gains ground daily, and would, if generally accepted, make the subject of this paper unnecessary. But, as long as through fault of the patient, or of the medical attendant, cases are allowed to progress to suppuration or gangrene, so long will the operative treatment be restricted in its beneficient results, and have failures to reckon with, from peritonitis, and from septicaemia. Should the operation have been performed in the "Appendicitis Stage" of the disease, the mortality would practically be nil. The germ of putrefaction ever present in an important state within us have been afforded an opportunity to develop, over a small or greater area of the appendix. A cut off circulation constricting bands, swelling and pressure against a fecal concretion within are the causes which so alter the tissues of the appendix as to remove from it all vital resistance and allow putrefactive germs to develop, as in the body after death. The irritation in the neighborhood is, in the majority of cases, sufficiently great for adhesions to have formed. The tip of the appendix, its base, its middle portion may partake in the abscess formation offering the particular spot undergoing gangrene, as a part of the abscess wall. The rest of the abscess wall is formed by knuckles of intestines in its immediate neighborhood. The appendix may point in any direction and may have hidden itself in any conceivable way between the caput coli and ilium. Temperature and pulse are unreliable indications of the gravity of the condition. The mixed infection may make the process slower, establishing a firmer or less firm fibrous isolating membrane, rupturing less easily or not, and regulating the possibility of disseminative peritonitis: This is a condition open to the most varying procedures. To ascertain absolutely whether the peritoneum is infected or simply irritated, whether irrigation should be resorted to or not, whether drainage of the abdomen should be closed, or the abscess region packed and the wound left open: If septicaemia be not already present, the judicious selection of one of the above methods of treatment establishes the difference between success and failure. It is difficult to establish at sight the difference between a violent irritation of the surrounding peritoneum, and a disseminated infection from the abscess. The formation of lymph membranes tending to agglutinate the neighboring knuckles of gut is an index of mere irritation by transuding toxins. This is not alarming and is but further and extended effort of nature to isolate the diseased parts. Not so, however, when the surrounding intestines are red, angry and distended, without adhesions. Here a genuine peritonitis extending from the abscess exists. It is caused by the germs themselves from the original focus of disease, and is a fair indication that the abscess wall has yielded, be it ever so little. In this case there is a certain amount of serous fluid,

free in the peritoneal cavity, although the inflamed area be limited to the intestinal knuckles in the immediate neighborhood of the abscess. In the cases denoted as abscess with surrounding irritation, the operative procedure indicated is the following: Isolate the abscess before opening, by surrounding it with large gauze pads, and thus protect the rest of the abdominal region from possible contamination, seek the appendix, extricate it from its adhesions, remove the pus by sponging, amputate the appendix: Scrape the abscess cavity gently with gauze: clean it further with hydrogen peroxide. The cavity is now packed with iodoform gauze, the orginal isolating pads removed, fresh ones substituted and the wound left open to granulate. A large amount of gauze is placed on the surface for absorption of drainage. This surface dressing should be changed every six hours during the first forty-eight hours. Under no circumstances should the packing be disturbed in less than forty-eight hours for fear of destroying the adhesions we hope to build. They may, however, remain much longer. At the end of this time, adhesions have sufficiently formed to enable us to remove the packing, as well as the isolating pads. The case will be treated subsequently by simply packing the seat of the abscess. This may be renewed every second day until granulations have finally filled the wound. Quite different indeed is the course to be pursued when a genuine local peritoneal inflammation exists with semi-purulent fluid free in the peritoneal cavity. The procedure just described fails absolutely here, and the disseminating peritonitis continues its course until a fatal termination. I have seen at *post mortem* the local seat of the abscess in a comparatively healthy condition while a general peritonitis extending from it has been the cause of death. Since this is the case we must reckon this particular condition in the same class as those of general peritonitis. In other words, general peritonitis, as we find it at operation, was at one moment in this same condition, and is only greater in degree and must be treated as such. The treatment of general peritonitis, is the same to-day, whatever be the infecting organism. The disease now to be treated is no longer appendicitis. The problem is to destroy the living germs which have invaded the whole surface of the peritonem, using the serum of their membrane as their culture food. Here nothing short of complete evacuation with careful irrigation of the whole abdominal cavity will suffice. Irrigation must be prolonged to the greatest extent endurable by the vital condition of the patient. Warm sterile water is the preferable irrigation fluid at a temperature, 102. In aggravated cases, I have seen irrigation continued after the patient has been returned to bed. With a large trocar an opening was made through the abdominal cavity in the right and left hypochondriac region. A large rubber tube about six inches long was passed through these openings. When the abdomen was sutured a similar rubber tube was placed at the superior and inferior extremity of the wound, making four tubes penetrating the abdominal cavity. The irrigating apparatus was connected with each of these tubes in turn. Irrigation was used every two hours in the first forty-eight. This mode of irrigation offers, I believe, the most prospect of checking by local means, a general infection of the peritoneum. Should, however, toxaemia exist, it is a separate disease, as it were, added to the appendicitis and peritonitis, and demanding treatment specially directed to it—death can result from toxaemia even though the peritonitis be improving or cured, this fact is illustrated by tetanus, though a local disease at first, subsequently becomes constitutional. We may resort to amputation of the infected limb, but even this would not suffice to check the fatal course of the infection beyond. Saline hypodermoclysis has been used with perhaps better results than any other remedies. Practically we are here limited to tonics and stimulants, a poor substitute, indeed, for a direct anti-toxin. These cases usually proceed to a fatal termination. A careful analysis of deaths due to appendicitis, or rather conditions caused by neglected appendicitis should help us to establish that appendicitis itself is not the terrible condition it is

thought to be: that the unfortunate sequelae, peritonitis and toxaemia, are the truly dangerous conditions, which an expectant, or medical treatment has allowed to exist. These two conditions present therapeutic problems that are still unsolved. The surgical treatment of appendititis proper is almost ideally perfect, and practically free from danger. Let us labor to impress these facts upon the profession at large, and the laity. Let us teach and practice so that no case ever goes beyond the stage of pure appendicitis, and insist that no medical man be excused from letting this precious stage pass by.

GANGRENOUS STOMATITIS.

BY WILLIAM A. SMITH, M. D.,
GLENDALE, S. C.*

This is a gangrenous process which usually begins upon the gums or inside of cheek, spreads very rapidly and usually terminates fatally; it is, fortunately, a rare disease. Various causes have been given for the gangrenous process in this disease, which I will not mention, more than to say it occurs more frequently as a complication of measles, but sometimes follows other exhausting diseases of infancy and childhood. The gangrenous process of Gangrenous Stomatitis being usually a secondary disease, the process is one of rapidly spreading gangrene, in most cases there are thrown out inflammatory products in quite large quantities with little or no tendancy to limitation of the disease. This usually advances steadily until death occurs. In a small number of cases a line of demarcation finally forms and the slough separates, leaving a large area to be filled in by granulations and cicatrization. The general symptoms are those of profound prostration and sepsis, temperature is generally from 101 to 104; of the local symptoms, often the first to attract attention is the odor af the breath, or, sometimes, the dusky spot on cheek or lip; on examination of mouth there is usually found upon the gums or inside of cheek a dark, greenish black mass, surrounded by tissues which are swollen and oedematous; externally, the parts are tense and brawny, from the swelling, this infiltration always extending for some distance beyond the gangrenous part; as the process extends, the teeth loosen and fall out, there may be necrosis of the alveolar process of jaw and perforation of one or both cheeks or lower lip,—extensive sloughing takes place in one or both sides, giving the patient a horrible appearance. The odor is very offensive, and, in spite of all our efforts at disinfection, the odor fills the house. Pain is rarely severe, and often absent; extensive hemorrhage is rare.

The text books say Gangrenous Stomatetis is more common in females than males. In May and June, 1892, there were three cases at Glendale, S. C., all males. Two of these cases I saw, one of which I had the misfortune to attend. The first one I only saw by chance—the family physician asking me to see it through idle curiosity,—the child I would say was about eight years old and in the advanced stage. The clinical history was that child's previous health had been good; had recovered from measles about ten days before and complained of sore mouth, which was paid little attention to by parents; asked the family physician to call and see the child, this he did and left a simple prescription, stating that child would be all right in two or three days, if not they could notify him. The following day physician was again called, and, to his astonishment, found two teeth ready to fall out, the gangrenous process continued till the entire face sloughed off above the supra orbital ridges, presenting the most ghastly appearance.

The next one was the unfortunate one that fell into my hands: On June 3, 1892, Mr. B——— asked me to call and see his boy, a child about 6½ years old, suffering from diarrhoea, which I did, and found the child had had fifteen stools in twelve hours; temperature 101, with the most offensive breath I ever smelt in my life. I examined mouth and found a gangrenous mass on left inferior maxilla

*Read before Spartanburg Co. Med. Soc., July 28, 1905.

and a hole about the size of a five-cent piece nearly through the left cheek, about one inch from corner of mouth, and the following two days the slough had extended through the corner of mouth. The process continued until the entire left cheek sloughed out to a line of demarrcation just beyond the angle of jaw, presenting a very horrible appearance. Treatment—text books recommend actual cautery after cutting away diseased parts or nitric acid, acid nitrate of mercury, peroxide hydrogen and curetting. In this case I used nitric acid twice daily and packed cavity with carbolized cotton, and later used Monsels' Sol., and packed as before. I gave a mixture of R. Tr. Iron, Chlo. Pot. Quin. and water. In three or four days after the iron mixture was given, the diarrhea ceased and child's appetite was good throughout entire course of disease. The remarkable feature was the child recovered and is still living, being able to open mouth about ⅛ of an inch. I removed with a pair of artery forceps about two inches of alveolar process of inferior maxilla.

Gentlemen, this case was treated by me purely on my own judgment, as in no text book I had at that time could I find anything I thought would give me any idea as to diagnosis, nor did I ever know until I saw a picture in Holt's book on diseases of children, 1898, that confirmed in my mind the proper diagnosis.

I hope the Spartanburg County Medical Association will overlook the shortcomings of this paper, it being the first I ever attempted to write, and cases reported being from memory, as I kept no notes, and occurred thirteen years and two months ago. I thank you very much for your attention.

ENTEROCOLITIS, OR SUMMER DIARRHOEA OF CHILDREN.*

J. L. JEFFRIES, SPARTANBURG, S. C.

Enterocolitis of infancy and early childhood may be considered to embrace all forms of summer diarrhoea from the loose alvine discharges due to indigestion and fermentation to the bloody mucous discharges of dysentery caused as we are now reasonably certain by a specific baccillus. From recent investigations of summer-diarrhoea from the standpoint of the bacteriologist we have learned that there is no uniform clinical picture presented but that the cases whose stools contain the specific baccillus includes all the varieties of illness that are commonly included under the head of Summer Diarrhoea. One authority divides or rather suggests a division of the cases in which the bacillus is found into two groups, *viz.*, the toxic group, which presents itself in varying degrees of severity, from the milder types of gastro-intestinal disorders to the types of profound poisoning resembling and often mistaken for cholera infantum. In this group, as in cholera infantum, the chief symptoms are apparently due to the absorption of toxins from the intestinal tract. The other group represented by those cases which show daily remissions of temperature with blood and mucous in the stools and occurring in varying degrees of severity is familiarly known as Dysentery.

This disease usually prevails at such times of the year when for several days and nights in succession the atmospheric temperature does not fall below 60 F., notably during the latter part of May, throughout June and July and to a less extent during August, by reason it is supposed of the longer and cooler nights of that month.

Cholera infantum as a type of summer diarrhoea occurring alone or as a complication of enterocolitis is deserving of special mention, for the reason that its primary cause is different from that of enterocolitis and the character and severity of its symtoms are for the most part very widely different from those of enterocolitis. Cholera infantum presents us with a clinical picture distinctly its own, and as such should be ever before our minds when called to the bedside of an infant suffering with very high temperature, extreme restlessness, constant nausea and vomiting, with frequent copious and thin watery stools.

*Read before Spartanburg Co. Medical Society, May, 1905.

With this brief mention of cholera infantum I should leave the subject and resume the subject of enterocolitis, with special reference to its dietetic management and medical treatment, presuming that all of us are familiar with its symtoms and diagnosis.

We are called to a child, say six months old, nursing a healthy mother, perhaps being fed other food besides the breast milk. Nausea, vomiting, with temperature and tenesmus coming on suddenly have made the Doctor's visit necessary, or the mere fact of the bowels moving too often the Doctor has been called in. If the child seems much sick we immediately empty the rectum and lower bowels with warm water enemata, just as in an ordinary case of indigestion in which this form of diarrhoea often finds its origin. The lower bowel emptied by the enemata pain and tenesmus for the time being relieved we order one-fourth grain of calomel and soda, repeated every hour until we have given three-fourths to one and one-half grains each, and then after a variable interval administer a dose of castor oil. This simple but effective treatment usually ends the trouble, even when the child is immediately put back to the breast, which should be withheld until ten or twelve hours have elapsed, in order to allow the stomach and bowel to be well cleared of all irritation before imposing other tasks upon it. If with this care and treatment of the breast-fed baby the bowels continue too loose and too frequent, a little bismuth and chalk mixture with some alkaline diuretic, either of ammonium or potassium (I am partial to potassium citrate in some palatable form) will soon restore the normal equilibrium and the child is well again.

These salts of ammonium and potassium are in my judgment very valuable aids, both as eliminants, diuretics and diaphoretics, and antipyretics, and certainly are far safer than any of the coal tar preparations.

There can be no doubt that the healthy breast milk has aided us very materially in our success in effecting so prompt a recovery. The nursing baby has a resisting power that the artificially fed baby does not possess, and we should never, unless the indications are very plain to the contrary, deprive a sick baby of a healthy mother's milk. If from fatigue, both physical and mental, the mother seems to nourish her child poorly, do not be too hasty in concluding that the breast milk is disagreeing with the baby, but seek first the cause in the mother, impress upon her the importance of taking sufficient sleep and suitable recreation, as well as giving proper attention to her diet and the condition of her bowels, and hold on to the breast milk and you will find the sick baby recovering where others deprived of it do not. We know that healthy nursing babies are peculiarly immune to the contagious and infectious diseases. The second summer, so much dreaded by mothers, only emphasizes the fact that the child totally or partially deprived of the breast and being fed on artificial and other kinds of food, its vital powers being lowered thereby, becomes the easy prey of stomach and bowel disorders. Breast milk then is our safest article of food, and our best means of prophylaxis when we are called on to treat a baby sick from any cause whatsoever, and especially when it is suffering from enterocolitis.

When called to the case of a child with enterocolitis who has been weaned or who for some reason has been artificially fed from birth, we have a decidedly more difficult problem to solve. Our initial steps in treating the case are about the same as in the case we have just mentioned. At first withholding all food for a time until we can get our calomel and oil to act, using nothing in the stomach except plain water sterlized and cooled, not ice water, and in quantities sufficient to satisfy thirst. The length of time necessary to withhold food varies with the intensity of the symptoms and the individual child. In my judgment we err more often in resuming food too soon—forty-eight to sixty hours may not be too long to withhold it. When we feel safe to begin feeding it is best, I believe, to withhold all milk and food preparations prepared of milk, and the artificial foods found on the market, or even the latter alone by reason of the excess of sugars

in their composition, and begin with small quantites of some one of the dextrinized gruels or rather some one of the cereal gruels, whether dextrinized or not, which time out of mind have served a good purpose for the sick. To Dr. Chapin, of New York, we are indebted for the discovery of a diastase made from malted barley which so modifies the cereal gruels that the resulting dextrinized gruel becomes as fluid as water, the insoluble starch being converted into dextrin and maltose, which are freely soluble in water and hence are made far more easily digested and assimilated than the crude starch of the gruel. These gruels alone or dextrinized are sufficient to sustain life. Mother's milk contains within normal limits 3 to 5% of fats, 1 to 2% of proteids, 6 to 7% of sugar and 0.2% to 0.3% of mineral matter. In the words of Chapin, "Cereals, like all foods, contain fats, proteids, carbohydrates, mineral matter and water." The dextrinized gruels containing as high as 3% proteids and 12% carbohydrates are rendered soluble by the dextrinizing process and thus are made almost perfectly assimilable. The dextrinizing process had been worked out by Dr. Chapin prior to 1904, but on account of the difficulties to be overcome in preparing and preserving the diatase it could not be put into practical use. Thanks to the Chemists who have overcome these difficulties and have given us a stable glycerite of Chapin's diastase known on the market as "Cereo," any druggist can obtain it for us ready for immediate use. One teaspoonful to half pint of barley gruel will completely thin the gruel in a very short time and thus prepared it may be seasoned with salt or sugar, or both, and fed to the sick child, either alone or as a diluent of egg albumen or milk when milk is readmitted to the dietary.

As valuable adjuvants in feeding we have at our command the meat juices, extracts, teas, broths, all of which are worth our consideration. They are good apetizers, and have some nutritive value. The liquid beef peptonoids are useful especially when the case is continued with emaciation and with high temperature, indicating inflammation and ulceration of the bowels. How much nutrient value is contained in the peptonoid preparations, per se, I do not know, but there is some, and in addition to this there is a certain percentage of alcohol in an assimilable form, and they are usually well borne, they should not, however, be relied on as perfect foods.

A word as to the preparation of egg albumen: To eight ounces of sterile water add the white of one egg, beat up thoroughly and strain through a clean cloth, then flavor with salt or sugar or both, add a little brandy or peptonoids and it is ready for use. Instead of water we may use as a diluent any one of the cereal gruels dextrinized.

As to drugs Bismuth Subnitrate still holds its place as our most useful drug—doses of five to ten grains each are usually well borne by most children. These doses are larger than most of us prescribe, but properly administered in palatable prescriptions will serve to check the bowels already cleared by calomel and oil, but still acting too freely and too frequently, when smaller doses might not do it. So good an authority as Southworth, of New York, advises that ten grains should be given every hour at first to children under one year of age until improvement occurs with the characteristic discoloration of the stools, then every two hours may be sufficient. "The discoloration being caused by hydrogen sulphide in the bowels can be produced by giving lac sulphur in grain doses for a sufficient length of time." When bismuth fails we may add opium, but not in a mixture, in any of its preparations best suited to the individual case. For my own part Tr. Opii deodorata seems to serve me best, then the preparations of potassium as aids to elimination administered in some of the forms named above or in the very excellent preparation composed of potassium bicarbonate, goldenseal, pancreatin and rhubarb sold ready prepared by the druggists.

Some of the complications to combat are nausea and vomiting, tenesmus and convulsions and extreme prostration. For prostration alcohol in some form is our

best remedy given in suitable doses to meet the requirements of the individual case, some can take very much more than others, but we should be careful that it does not upset the stomach. Burnt whiskey, part of the alcohol being burned away, is to many children an agreeable and by many children better borne than plain whiskey, though of indefinite strength, and for that reason not so reliable a stimulant.

For tenesmus we have in cocaine when properly used a most effective remedy. Some of our best authorities advise it used in ¼ grain doses inserted into the rectum by means of a suppository, this being repeated at three and four hour intervals until the child is relieved.

I believe that far less than that amount is sufficient for most cases, 1/12th to 1/20th grain of cocaine in a readily soluble suppository combined with pulv. Dov. camph., and one grain bismuth subnitrate in my judgment is sufficient for a child eighteen months old. More repeated at three and four hour intervals I fear to be dangerous.

For nausea and vomiting a little shaved ice given frequently, bathing the lips and gums with mint or camphor water often help the little sufferers. I am afraid of cocaine and chloretone and other similar drugs, but believe they serve a useful purpose in the control and prevention of nausea. We should, however, try the milder remedies first.

For convulsions the treatment should be directed to the immediate cause if such be possible, but the appearance of even slight convulsions in the later stages of enterocolitis is an evil omen, and indicates that the brain has suffered from the drain upon all the tissues as well as from the toxic effects of retained poisonous products, of defective secretions and excretions. What to do under such circumstances taxes all the resources of the physician. As for myself I fear that I cannot do enough and I also fear that I may do too much. It seems to me that all treatment in this condition is unsatisfactory. The bromides, hyoscyamus, belladonna have all been tried with doubtful results. Morphine hypodermically to suit the individual case and to secure immediate relief, then vigorous efforts to secure effective elimination, both from the kidneys and the bowels, is our most reliable plan of treatment, and is sometimes productive of good results.

For high temperature cold packs to the head, cold water enemas, and cold sponging all have their uses within judicious limits. In my judgment it is unwise to administer the coal tar preparations at any time during the later stages of enterocolitis. Enemas of normal salt solution are stimulating, eliminant, and being readily absorbed by the tissues are in my experience our safest means of relieving high temperatures. Ordinarily when daily irrigation of the bowels seems necessary on account of high temperature and foul smelling stools, the child's condition otherwise being good, one or two bowel washings a day is amply sufficient, more, I believe, does harm and the fewer in the aggregate the better. In some cases bowel washing seems to be of great service, in others it, in my judgment, increases tenesmus and produces prostration. Its effects should be closely watched at all times and at the first appearance of symptoms of collapse the washings should be discontinued. The indiscriminate use of high rectal enemas should be looked upon by conservative physicians with condemnation, they should be given by the physician only or by a competent nurse, and only when deemed safe and absolutely necessary.

Again we would do well to avoid undue purgation. Calomel and oil and other purgatives often do good, but I believe in the weak and emaciated little sufferers they do harm more often than they are thought to do, and as most of us are aware, oftentimes aggravate the case and cause its recovery to be retarded.

MISCELLANEOUS.

In view of its present importance we deem it wise to publish the following which was sent to postmasters in the Southern States by the Treasury Department.

STEGOMYIA FASCIATA.

Treasury Department,
Bureau of Public Health and Marine Hospital Service,

WASHINGTON, July 31, 1905.

NOTE.—The measures herein mentioned were recommended by the army medical board of 1900 and have been indorsed by the American Public Health Association and by the First International Sanitary Convention of American Republics. They have also been justified by the experiences and observations of the two working parties of the Yellow Fever Institute of this Bureau in Vera Cruz, Mexico, and by the commission of the Pasteur Institute of Paris, France, operating in Rio Janeiro, Brazil. The measures have been tested successfully on a large scale in Havana, Cuba, and during the yellow fever epidemic at Laredo, Texas., 1903.

The infection of yellow fever is carried by mosquitoes, and by no other means is the infection spread.

Persons take the disease by being bitten by mosquitoes that have previously bitten a yellow fever patient.

The mosquito to become infected, must bite a yellow fever patient during the first three days of his attack. These first three days, therefore, are the most important time for preventing the access of mosquitoes to a fever patient.

It is often difficult to decide during the first three days whether a patient has yellow fever; hence the necessity in threatened communities of placing a mosquito bar immediately around every patient who has fever of any kind, and for three days at least.

FACTS ABOUT SCREENING.

1. The netting used should have meshes fine enough to prevent the passage of mosquitoes (at least 18-20 meshes to the inch).
2. It is important to screen the windows and doors of the house. It is doubly important to screen the beds of fever patients.
3. Mosquitoes can bite through mosquito nets when any part of the patient's body is in contact with the netting.
4. Frequent examination should be made to see that there are no torn places in the netting or that no mosquitoes have found a lodgment inside.
5. The netting should be well tucked in to keep mosquitoes from entering.
6. If mosquitoes are found within the netting they should be killed inside and not merely driven or shaken out.
7. All cases of fever should be promptly reported to the local health officer. Awaiting his arrival they should be covered with a mosquito bar.
1. Mosquitoes live in the vicinity in which they breed. They do not often fly a long distance.
2. Mosquitoes breed only in water—usually in artificial collections of fresh water.
3. The young mosquito, or wriggler, lives in water at least seven to twelve days.
4. Although the wrigglers live in water, they must come frequently to the surface to breathe.
5. Coal oil on the surface of the water prevents the wrigglers from breathing.
6. Destroy the breeding places and you will destroy the mosquitoes.
7. Empty the water from all tubs, buckets, cans, flower pots, vases, once every forty-eight hours.
8. Fill or drain all pools, ditches, unfilled postholes, and the like.
9. Change regularly every day all water needed in chicken coops, kennels. etc.
10. Treat with coal oil all standing water which cannot be drained (1 ounce of oil will cover 15 square feet of surface). The oil does not affect the water for use if the water is drawn from below.
11. Where oil is applied to standing water it must be distributed evenly over the surface.
12. Put fine wire netting over cisterns, wells, and tanks of water in every day use.
13. Places in which it is undesirable to put oil, such as watering troughs for stock, lilly ponds, and so forth can be kept free from wrigglers by putting in goldfish or minnows.
14. Clean away all weeds, grass, and bushes about ditches, ponds, and other possible breeding places, since these afford a hiding place for the mosquitoes.
15. Clean up vacant lots and back yards of all cans, tins, bottles, and rubbish.
16. First do away with, or treat, all places where mosquitoes are known to breed, and then begin to work on places where they might breed.
17. Inspect and treat with coal oil, gutters, culverts, ditches, manholes. catching basins, etc., along the roadside. Manhole covers should be screened.
18. Houses should be cleared of mosquitoes by burning 1 pound of insect powder or 2 pounds of sulphur to 1,000 cubic feet of space. The mosquitoes will fall to the floor and should be collected and burned.
19. Success in mosquito destruction depends upon the co-operation of the members of the entire community.
20. While the infection of yellow fever is carried by a single species of mosquito (the stegomyia), to insure its destruction it is necessary to destroy all mosquitoes.

In places liable to yellow fever both individuals and communities have an effective method of protecting themselves, as indicated above. Use the mosquito bar at once over all cases of fever until the danger from yellow fever has passed. Destroy all mosquitoes.

WALTER WYMAN,
Surgeon-General.

COMMUNICATIONS FROM COUNTY SOCIETIES.

ORANGEBURG, S. C., Sept. 6, 1905.

Last Monday Dr. T. G. Croft, of Aiken, Councillor, 2nd Dist., addressed a meeting of the physicians of Orangeburg County, advising organization of county societies. After his talk, a permanent organization was effected, adopting the constitution and by-laws as proposed by A.

M. A., with only such change as needed to meet local conditions. I am without a copy of this Constitution and By-Laws and will ask you to send me one so that I may order the required number for the society's use.

As soon as the annual dues are paid I will write to you for a charter. Enclosed I send a list of the members enrolled to date. Think this will be greatly augmented in a short while, and finally embrace every legalized practitioner in the county. Please send these members the State Journal. Thanking you, I am,

Very truly yours,

LIN. C. SHECUT, Sec'y.

ORANGEBURG COUNTY MEDICAL ASSOCIATION.

Sept. 6, '05.

Prest.—W. L. Pou, St. Matthews.
1st V.-P.—M. J. Dantzler, Elloree.
2nd V.-P.—M. S. Gressett, Branchville.
Sec'y and Treas.—L. C. Shecut, Orangeburg.
A. R. Able, St. Matthews.
L. B. Bates, St. Matthews.
M. G. Salley, Orangeburg.
L. K. Sturkie, Orangeburg.
J. G. Wannamaker, Orangeburg.
J. A. Jeffords, Orangeburg.
D. D. Salley, Orangeburg.
Jesse A. Clifton, Orangeburg.
A. W. Browning, Elloree.
W. H. Lawton, Vance.
S. J. Summers, Cameron.
P. L. Felder, Elloree.
J. M. Oliver, Orangeburg.
T. C. Doyle, Orangeburg.
W. R. Lowman, Orangeburg.
W. L. Mack, Orangeburg.
J. D. S. Fairey, Orangeburg.
A. S. Hydrick, Orangeburg.
D. J. Hydrick, Orangeburg.
Geo. H. Walters, Orangeburg.

SPARTANBURG, S. C.

Spartanburg County Medical Society held their regular meeting Aug. 25, 1905. Meeting was well attended. Dr. A. D. Cudd read a paper on "Floating Kidney." Dr. Fred. L. Potts on "Suppurative Appendicitis." Dr. J. H. Allen is ill with typhoid fever.

Dr. H. R. Black is spending a month in Philadelphia.

Drs. J. E. Edwards, of Abbeville, S. C., and A. K. Taylor, of Tarboro, N. C., have located in Spartanburg.

LETTER TO THE EDITOR FROM THE COUNCILLOR OF THE SECOND DISTRICT.

My dear Doctor:—

I was at Orangeburg yesterday and succeeded in organizing their County Society. They start with a membership of 22, and I believe in a few months will be raised to 30 or 40. They have good material in this county, and I do not see why it will not make one of the best societies in the State. The secretary will shortly send down the list of members to Dr. Whaley and get them on your list for the *Journal*.

I congratulate you and your co-workers in the bright and pithy little journal you give us.

With kind regards, I am,

Very truly yours,

T. G. CROFT.

UNION, S. C.

Editor *Journal* S. C. Medical Association, Charleston, S. C.

My Dear Sir:—

It is with pleasure that I announce that the Union County Medical Society, immediately upon receipt last April of the new Constitution as recommended by the National Association, was reorganized, and is now working under a charter from the State Association.

This new arrangement has proven very satisfactory to us, and has been the means of adding several members to our society, yet there are a few reputable physicians in the county not members, but we hope to have them enrolled before the next meeting of the State Association.

We find the weekly meetings very satisfactory, with fully as large an attendance as with the monthly, or semi-monthly meetings.

The reading of papers, and the report of clinical cases bring out a very liberal discussion, and each member leaves the meeting with a feeling that he has added to his store of knowledge something new, or something forgotten which will aid him in relieving the ills of his fellow man.

The Union physicians of the old Medical Society started a movement last year to establish an hospital here, and it is very gratifying indeed to note that under the new organization matters are progressing more favorably, and we hope before the autumn is past to have the plans so matured that work shall at least have been begun on the building.

Yours fraternally,
THEODORE MADDOX, Sec'y.

A SPECIMEN FROM THE LAST EXAMINATION BY THE STATE BOARD.

The following is one of the papers presented during the last session of the State Board. It is given literatim and verbatim.

SOUTH CAROLINA STATE BOARD OF MEDICAL EXAMINERS.

Materia Medica and Therapeutics.

JUNE 13, 14, 15, 1905.

DR. J. L. NAPIER, EXAMINER.

Give dose, intervals between, physiological effect, class, and therapeutics of:—

Question 1. Digitalis Tincture.

Answer (a) Digitalis Tinct. Dose, from 1 to 10m. The Doses can Be givon in intervals of ever 3 hours at 2m Doses for some hours. But in givon Digitalis The heart must Be watched for some times Very small doses means great effect over some people than it do in others. I will say the intervals must Be governed By the action of the heart.

(b) Digitalis has great effects over the heart muscles and percautiones must Be looked after when the administer this drug. It slowes the heart beat and does So By the effects it has over the muscle of the heart.

(c) In therapeutics uses of digitalis Is used in cases where the heart is beatting to fast and is used in cases of heart deases. Mitral regurgitation and Oartic regurgitation, and is used in cases of Nephritis where the heart is incresed in its action.

It can be used in cases in where the heart is increase in its force and the muscle of the heart is not effected.

Question 2. Stophanthus Tincture.

Answer (a)—Strophanthus Tinct. Dose 1 to 10m. It can be givon at intervals of 3 hours. at 3m at a dose. and can be givon in larger doses.

(b) Physiological effect. it/has a great effect over gastro intestine tract it actes as a eritant to the stomach when it is givon in large doses.

(c) and it is used in cases of deases of the gastro intestine tract as in eritation. it is also use in a general weakon system.

Question 3.—Strychnine Sulphate.

Answer (a) Strychnine Sulphat. Dose 1-60 to 1-30 gr. In ad ministerig it must be guvern By the heart action and it has greater effectes over some people than it dow over other.

It can be givon at intervals. 1-60 gr 3 times a day. with no bad Results.

(b) The Physiological effects is its great effectes of stimilating the nerves of the System and increasing the action of the heart. and it does this By the effectes it has over the nerves of the heart centers.

(c) Therapeutics actions is its uses in increasing the Rates of the heart Beat and is use in cases of Stimilating the Nerveous System and Sometimes used in cases of Blood effection where the Blood has a slow action. used in cases of nerveous deases. to stimilate them.

Question 4. Veratrum Viride Tincture.

Answer (a) Veratrum Viride Tinct. Dose, from 1 to 2 dr. It can be givon at intervals 1 dr at 4 hours intervals.

(b) Physiological effectes it effectes or rather a eritante to the intestine camal use in case of causing the intestine canal wall to become in a acting condition.

(c) And is used in cases of penuomes and in any Organition in the intestine canal.

Question 5.—Nitro Glycerine.

Answer (a) Nito glycerine? Dose, gr 1-100 to 1-150. The intervales of giving this drug must be givon By the effectes it gives or rather effectes the heart. But it can be givon at intervales of 1-50 gr. ever 3 hours with Out any bad Results.

(b) Physiological effect. it has a effect to stimilate the heart centers and increase the action of the heart, and it increases the action of the heart By effecting the centers of the heart and effecting the muscle of the heart.

(c) Therapeutics effection of nitro glycerine Is used in case of heart deases in where the heart is become slowened in its effection.

In cases of frightes in where the heart has become slowened. Sometimes it is used in cases of pationt getting too much anesthenia and the heart becoming slowened.

In answering the following questions, give doses of drugs used; the frequency with which the dose is repeated; the physiological effect, or why did you give it.

Question 1.—Dysentery.

Answer Dysentery. first in a case of Dysentery first give a purge. and this purge is given to clean Out all the intestine canal now the drugs used for the Dysentery can have a better effect.

For Dysentery.	Bithmus Sub.	dr. 3
	Bithmus Subgal.	dr. 3
	Opii Tr.	dr. 2
	Elixir pepsin	Dr 2
	aquae to make	oz. 4

M. Sig. teaspoonful in little water ever (2) two hours.

In this I give the Bithmus for a protecting coat for the intestine wall.

And the Opium for or rather to controle the pirstactic movement of the intestine. and the pepsin more as a effect for the Stomach.

Question 2.—Cholera Infantum.

Answer IN a case of this kind I would give doses of morphine 1-30 to a child and increase as they required to be done The resion of giving morphine is to releave the child of its Suffering and to keep it at Rest.

Question 3.—Pneumonia.

Answer. Pneumonia. in case of this kind you wold use hot application to effected part and wold give strychnine to increase the heart action when it is Kneeded.

wold use hot applications to keep the effected part warm to try and keep it from becoming in a consolidated forme, wold use strychnine to increase the action of the heart when it has become slowened. By the great worke it has to do. When the pneumonia it depresses Over the heart and causes it to become slowened. then give Strychnine.

Question 4.—Pleuritis.

Answer. None.

Question 5.—Hay fever.

Answer. None.

Question 6.—Partussis.

Answer. None.

Question 7.—Nephritis Acute.

Answer. In Nephritic acute wold give in this condition get the skin in good acting condition and wold give acetate Potash for the effectes of aleminating.

The kitnys in a good acting condition. give 5gr. 3 times a day. Buch is use 3m 3 times a day Sometimes.

But you wontes to get the Skin in a good acting condition for or rather to keep work off of the knitnys and acetate potash to keep them in good condition.

Question 8.—Icterus Catarrhal.

Answer. None.

Question 9.—Laryngismus Stridulus.

Answer. None.

Question 10.—Rheumatism Acute.

Answer. Rheumatism acute. In this condition wold give Salcylate of Soda. in Doses from 10gr. ever 4 hours.

wold give it for its great effect it has over the muscles and wine cholconm is givon in dose of 5m 3 times a day for the effect that it has over the muscles.

NOTES AND REVIEWS.

Surgery.

T. P. WHALEY, M. D.

APPENDIX AND PELVIC DISEASE.

In the *American Journal of Obstetrics and Diseases of Women and Children*, August, 1905, Reuben Peterson, of Ann Arbor, Mich., contributes an excellent article on the "Relation of the Appendix to Pelvic Diseases," claiming that the appendix should be removed as a routine measure when doing other intra-abdominal work on the pelvic organs, and quotes 200 cases, previously reported by him, in which just a little over 50% of the appendices were found to be microscopically normal, and reciting 82 recent cases in which 49%, or practically 50%, were found normal. He concludes by stating that, "Since it is impossible for the surgeon by gross appearances alone, to determine which appendix is diseased, and since nearly 50% of appendices, when the abdomen is opened for other purposes, are found microscopically to be diseased, it is the surgeon's duty in the absence of contra-indications, to remove the appendix in every case, otherwise he will leave behind diseased appendices which may prove a subsequent source of suffering to the patient."

REMOVAL OF APPENDIX WHEN OPERATING FOR OTHER TROUBLE IN THE PELVIS.

In the *American Journal of Obstetrics and Diseases of Women and Children*, August, 1905, Dr. W. A. Baker, of Boston, Mass., contributes an article entitled "Reasons for Removing the Vermiform Appendix in Nearly all Cases Where the Abdomen is Opened for Other Lesions." He cites a number of cases and concludes that:

First: The presence of adhesions of, or fecal concretions within, the appendix are not the only evidences of appendicitis which should influence the surgeon for its removal.

Second: The appearance of the normal appendix at the time of the operation has proved to be unreliable, as three-fifths of the cases reported were suffering from chronic appendicitis.

Third: The advantages to be derived as a propylactic measure for the removal of the appendix even in cases which prove normal far outweigh the slight additional risk incurred by operation.

Fourth: The great frequency with which appendicular troubles present themselves warrant not only the removal of the appendix, where it is easily accessible, when performing abdominal section for other lesions, but also the careful searching for and removal of it even though it may appear normal from its gross appearance.

CONCLUSIONS AS TO THE EFFECTS OF X-RAYS ON MALIGNANT GROWTHS.

In the *Annals of Surgery* for August, 1905, Dr. Wm. B. Coley, of New York, concludes a most excellent article on "Final Results of the X-Ray Treatment of Cancer," including Sarcoma, as follows:

The results of the x-ray treatment of malignant tumors up to the present time have proven,

1. That the x-ray exerts a powerful influence upon cancer cells of all varieties, but most marked in cases of cutaneous cancer.

2. In many cases, chiefly in superficial epithelioma, the entire tumor may disappear, probably by reason of fatty degeneration of the tumor cells with subsequent absorption.

3. In a much smaller number of cases of deep-seated tumors, chiefly cancer of the breast and glandular sarcoma, tumors have disappeared under prolonged x-ray treatment. In nearly every one of these cases, however, that has been carefully traced to final result, there has been a local or general return of the disease within a few months to two years.

4. In view of this practically constant tendency to early recurrence, furthermore, in the absence of any reported cases well beyond three years, the method should never be used except in inoperable cases, or as a prophylactic after operation, as a possible, though not yet proven, means of avoiding recurrence.

5. The use of the x-ray as a pre-operative measure in other than cutaneous cancer is contra-indicated, 1, because the agent has not yet been proven to be curative; 2, because of serious risks of an extension of the disease to inaccessible glands or to the other regions by metastases during the period required for a trial of the x-ray.

Materia Medica and Therapeutics.

J. L. NAPIER, M. D.

At the request of the editor of *Journal*, I have agreed to edit the department of Materia Medica and Therapeutics. It will be my aim to make this part of the *Journal* as much of a success as I can. To do so I ask the members of the Association to assist me by reporting the treatment of any of their cases of interest, especially any thing new they may have discovered in treatment. Also any new drugs they may have used with success.

No one man can settle any thing in our profession, but by compiling the results of treatment in any given disease, or the use of any particular drug, a definite conclusion can be reached. There is no reason why the *Journal* should not be the equal of any and all that is necessary to make it so is for every man to do his part.

J. L. NAPIER.

THE TREATMENT OF HEMOPTYSIS.

Francis Hare, of Brisbane, in *American Medicine*, of April 1, 1905, reports his results and those of others in his method of treatment. He sums up the matter by stating that of 16 atacks of hemoptysis occurring in 9 consecutive cases (8 tuberculous, 1 mitral) and treated by amyl nitrite inhalation, all save one ceased within three minutes; in the exception cessation was delayed for ten minutes.

The treatment has obvious advantages. In hemoptysis there is a highly vicious circle in operation. The intrapulmonary irritation of effused blood causes cough; coughing, like any other sudden exertion, causes rise of blood-pressure; rise of blood-pressure induces fresh bleeding; and so on, the circle continuing to revolve in many cases until the loss of blood has been sufficient to reduce blood-pressure materially and thus end the hemorrhage. This natural cure was at one time imitated by physicians who resorted to the lancet. The treatment by amyl nitrite is another imitation, less complete, but more economic than venesection. The circle is broken at the same point and by the same means, namely, reduction of general blood-pressure, but the blood being saved, the procedure may be repeated as often as necessary.

The drug causes no interference with cough; it is the influx of blood to the ulcerated lung tissue which is stopped, not the efflux from the bronchial tubes. Consequently blood-pressure already effused is rapidly cleared, retention and subsequent septic pneumonia obviated.

So far as the writer knows the treatment is absolutely safe, and is easily and rapidly applied. Hence it can be used by the patient in the absence of professional supervision, a point of considerable practical importance. It is a matter for surprise that the freedom from hemorrhage conferred by a drug whose influence is so fleeting should last so long as seems to be the case.

SCOPOLAMINE AS A GENERAL ANESTHETIC.

Terrier (*Bull, et Mem. de la Soc. de Paris*, No. 6, 1905) in a report on the use of scopolamine, as a general anesthetic in surgical practice, publishes the results of twenty-six trials of this agent. Scopolamine, the anesthetic properties of which were brought under the notice of French surgeons by Desjardine at the end of last year, is extracted from the *Scopolia japonica*, and is chemically identical with hyoscine, although possessing different physiological action. The anesthetic effects were studied by injecting subcutaneously a solution of a milligramme of scopolamine with a centigramme of morphine in a cubic centimeter of distilled water. An injection of this solution made four hours before the time of the surgical operation is followed by a second injection after an interval of two hours, and by a third after a further interval of one hour. After the first injection the patient, in the course of half an hour, gradually falls into a deep but quite natural sleep, the respirations being quiet and the reflex movements readily excitable by external influences. After the second injection the reflexes are diminished, the respirations become less frequent, and the pulse is accelerated. The patient is now in a heavy sleep, from which he can be aroused for a moment by shaking. The third puncture, which is not felt by the patient, is followed by a still deeper but quite physiological sleep, by dilatation of the minute blood-vessels of the face, indicated by congestion, the pulse being full, regular, and rapid. The pupils are dilated

and the eyeballs rotated upward and a little outward. Notwithstanding this state of intense stupor there is no complete relaxation of the limbs, and it is necessary during the removal of the patient to the table, and also during the operation, to avoid any disturbance from noise or talking, and to protect the eyes from light. There is, however, marked and persistent anesthesia over the whole of the surface of the body, and the cutaneous sensibility to pinching and pricking is completely abolished. The patient continues to sleep deeply and quietly for four or five hours after the operation, and after a slow awakening is restored to a natural condition. Anesthesia persists for some time after the renewal of the cerebral functions, so that the patient remains comfortable and free from pain in the wound for the first twenty-four hours after the operation. There is freedom also from headache and from nausea and vomiting.

The author points out that this method of producing general anesthesia has the following advantages: (1) It suppresses any apprehension of the operation. (2) The state of anesthesia is not preceded by excitement, and thus a cause of syncope is avoided. (3) The nausea, vomiting, and malaise which so often follow other methods of producing anesthesia are not observed after the use of scopolamine. The patient awakes in a normal manner from his deep sleep, and then does not feel the slightest malaise, and is able at once to take fluid and even solid nourishment. (4) The persistence of anesthesia after the awakening of the patient enables him to pass the night in comfort and in freedom from pain at the seat of operation. (5) The injection of scopolamine is not followed by albuminuria. (6) This agent does not act on the heart or lungs, and causes no bronchial irritation.

On the other hand, there are certain disadvantages attending this new method. Scopolamine is very uncertain in its action, and it is sometimes necessary to have recourse to the inhalation of chloroform or ether. It is, moreover, a very unstable substance, so that it is necessary to use only such as is quite fresh and pure. A serious inconvenience is the vasodilatation it causes, which in operations on very vascular tissues necessitates careful precautions for arresting hemorrhage, and prolongs the operation. Another disadvantage attending the anesthetic action of scopolamine is the persistence during such action of contraction of the abdominal wall. This complication, which tends to contra-indicate the use of scopolamine as an anesthetic in abdominal surgery, might, the author thinks, be prevented by making only one subcutaneous injection of the solution.

In conclusion, the author holds that scopolamine possesses the great advantage over all other general anesthetic agents of being free from danger.—*British Medical Journal*, March 25, 1905.

Obstetrics and Pediatrics.

LANE MULLALLY, M. D.

Cesarean Section.—Much attention is at present being paid to the subject of Cesarean Section, and the results obtained by various obstetricians in cases of Cesarean section encourage one to extend the field of this operation.

Voorhees (*Am. Jour. of Obstet, &c.*, Aug.) in a most excellent article entitled, "Seven Cesarean Sections," says:

Every day the operation of Cesarean Section is becoming more and more common, and the indications more and more relative. Only a little over a decade ago to deliver a woman by the abdominal route meant taking great chances for the mother's life. * * * * * * * To-day, a Cesarean section creates no wonder. * * * *

The results at large are so excellent that no careful surgeon, who is sure of his aseptic technique, who has an average amount of skill, and who has ordinary assistance, should be afraid to perform the operation on proper cases. Vorhees says the greatest danger is *infection*. That in the border-line cases where labor has been induced with the hope of a normal process or an easy forceps or version delivery, the possibility of infection always confronts us, but in some of these cases he believes you should take the chance of infection, though almost all operators who have the lowest mortality for Cesarean section will not take such chances. That Williams and others advocate in cases where one is not absolutely sure of his asepsis, that if Cesarean section is decided upon a modified Poro operation ought to be performed.

Spreading the omentum over the uterine incision when infection is possible will tend to localize the process at this site and prevent an involvement of the general peritoneum.

The second danger is hemorrhage, mostly to be feared when the operation is done where labor has started.

The third danger is shock, which he claims as a rule, is much less after Cesarean section than after prolonged forceps operations or a difficult craniotomy. When a hysterectomy is performed after removing the child the shock is considerable, consequently this extra risk is an additional contra-indication against removal of uterus.

The fourth danger is in the detachment of an embolus.

Voorhees says that the absolute indication for Cesarean section should be a pelvic diameter 7 cm. or less. He believes that if a version is done when the child is of a fair size and the pelvis moderately contracted (an internal conjugate of 8.50 cm. or under) especially in justo-minor pelvis, most of the babies will be lost. He condemns prolonged high forceps operation, pulling for one half, three-quarters or an hour without any advance of the head. When, however, the woman is in unfavorable surroundings and is already in such poor condition after a protracted labor and bad management that infection is certain, craniotomy should be selected, even though the child is living and in good condition. Though difficult craniotomy is often more dangerous for the mother than Cesarean section.

The operation for symphyseotomy is surely on the decline. That when any operation performed in the interest of the child carries with it such a high fetal and maternal mortality, when the convalescence from any operation is so prolonged and so interrupted by annoying and dangerous complications, and when the patient can be threatened with misery of chronic invalidism, we have no right in recommending a symphyseotomy in place of another operation. Such as Cesarean section which is less dangerous and presents far better results. Voorhees closes his article with the following conclusions:

1. That Cesarean section is a dangerous operation only when infection is present.

2. That there are too many fetal deaths from the other major operations.

3. That in view of the low maternal mortality the field for Cesarean section should be broadened.

4. That in contracted pelvis of a moderate degree (in the borderline cases) a late induction of labor is justifiable.

5. That when possible difficult versions prolonged high forceps operations performed early in labor should be avoided.

6. That craniotomy on a living baby is an operation only of necessity and emergency.

7. That symphyseotomy is an operaton of the past. Cesarean section in late labor. Holmes (*Am. Jour. Obstetrics, &c.*) believes that the appropriate time for abdominal hysterectomy is at term before labor has begun or not long after active contractions have been in progress. He believes that in contracted pelvis the upper limit for an absolute indication for a Cesarean section should be 7 cm., at the same time he still believes that craniotomy even on the living child is the only rational and scientific procedure in certain cases.

The contra-indications to Cesarean section in late labor center in the following facts:

1. Prolonged labor lowers the woman's resistance to shock.

2. Prolonged labor conduces to atony of the uterus, therefore, to hemorrhage, occasionally necessitating hysterectomy.

3. Prolonged labor develops certain effete substances. catabolic products, which are eliminated more slowly than they are produced; possibly lowering immunity by a species of auto-intoxication, therefore infection is more prone to occur.

4. During a protracted labor certain secretions, blood, mucus, etc., are poured into the uterus and vagina, which offer excellent culture media for the development of bacteria, normally present in the parturient canal, or introduced by examinations. In protracted labor we often see intrapartum infections, which promptly disappear with the evacuation of the uterus, or run a course as a puerperal infection.

This danger is increased by attempts to deliver per vaginam before the abdomen is opened.

5. After the membranes have projected through the os externum, or the head has moulded into the os, they are exposed to the contamination of the vagina; in removing the secundines and the child through the uterine incision they may soil the peritoneum or wound.

6. The prolonged labor frequently is the determining factor in the death of the child, or at least so jeopardizes its life that its prospects are curtailed.

If attempts to deliver have been instituted, it should be remembered that forceps occasionally will seriously maim the child, so it dies later, yet in utero the heart tones remain regular and strong.

He reports a case operated on in the country, and cites that the favorable circumstances for Cesarean section when the good condition of the child. natural strength of the woman, and that she was in the country, thereby minimizing the danger of infection.

PREVENTION AND MANAGEMENT OF SUMMER DIARRHOEA.

Kerley (*Med. Record,* New York) says that this is entirely a matter of education, that his orders in any household he attends where there are children is: As soon as the first sign of intestinal trouble shows itself stop milk, and give two teaspoonfuls of castor oil.

Put the child in the coolest room in the house, and secure rest and quiet. Use boiled water for drinking. Barley water or rice is used for nourishment.

When you return to the milk have it skimmed and give it in cereal water, in small quantities, ½ ounce at a feeding.

He relies on just four drugs, Calomel, Castor oil, Bismuth and Opium. He gives Bismuth in large doses. but is very careful in the administration of Opium, using Dover's powder.

He describes the indications for irrigation of the colon.

Southport (*Med. Record,* N. Y.) says, from the moment the child is born pro-phylactic measures should be instituted to prevent summer diarrhoea, and the most important is breast nursing. The usual diagnosis of "teething" assigned for every illness in young children is one of the difficulties that has to be overcome.

GYNECOLOGY.

CHAS. M. REES, M. D.

THE VAGINAL VS. THE ABDOMINAL ROUTE IN PELVIC OPERATIONS.

From the transactions of the Southern Surgical and Gynecological Association, 1903. In an excellent paper on "The Technique of Pelvic Operations, N. Y., by Vaginal Section," Dr. J. Riddle Goffe, N. Y.. the author strongly advocates the adoption of vaginal section, and states that he is glad to report continued satisfactory results in his hands, and of its steady growth in popularity throughout the country. The most marked examples of this are at St. Joseph's Hospital, Yonkers, New York, in which the entire visiting staff of surgeons—six in all—have as a routine method adopted the vaginal route for pelvic diseases to the almost complete exclusion of abdominal section, and with such improvement in their statistics that they are all ardent advocates of this method. With them every disease confined to the true pelvis is attacked through the vagina. In summing up his experience the author says:

The following conclusions are fairly indicated, not only from my own personal experience, but from what I believe a candid study of the table of cases would teach.

1. The vaginal route is most useful for reaching and operating upon the round ligaments, in cases of retroversion of the uterus or procidentia; also for removal of small fibroids, either subperitoneal or pediculated, for conservative work on the ovaries or tubes. or for removal of these organs.

2. The posterior incision is most useful for drainage in cases of pyosalpinx salpingitis, pelvic abscess, some cases of tubal pregnancy with haematocele and puerperal sepsis either with or without involment of the tubes? for oophorosalpingestomy, when the ovary is held backward and downward by old adhesions, and even in some cases of general septic peritonitis. The author further states: The more I see of this work the more I am impressed with the important truth that no pus tube should be attached by any other route than by the vagina. He further says, in my hands the scope of the operation, i. e., the conditions to which it is applicable, is steadily widening. It is no longer confined, on the one hand, to simple puncture and drainage, nor limited on the other hand to the radical operation of hysterectomy. All the intermediate procedures that are called for by the multifarious pathological conditions found in a woman's pelvis find their most direct route through the vagina.

Two incisions are employed by Dr. Goffe to reach the pelvic cavity through the vagina; one posterior to the cervix into Douglas's pouch, and the other anterior to the cervix separating the bladder from the uterus. The anterior incision is the one which he most frequently employs.

The anterior incision is made as follows: A transverse incision is made in front of the cervix, as is done for vaginal hysterectomy. through the vaginal mucous membrane and sheath from the uterus up to the peritoneal fold. The second incision consists of a longitudinal incision through the vaginal mucus membrane and sheath throughout its entire length. This second incision is accomplished by grasping the edge of this transverse incision, either side of its middle point, by two artery clamps. Tension upon these puts the anterior vaginal wall upon the stretch, and an incision is made with the knife from the neck of the bladder down to the centre of the transverse incision. The purpose of the second incision and separation of the bladder is to secure sufficient room in which to work. In the discussion which follows Dr. Goffe's paper, the concensus of opinion and experience was not in accord with Dr. Goffe's method, and rather than gaining in popularity, was losing. Those surgeons who had for a time given up abdominal section for the vaginal route, were fast returning to the abdominal incision, and found the vaginal incision greatly restricted in its usefulness

THE MORTALITY OF GOITRE CASES WITH REFERENCE TO GYNECOLOGICAL OPERATIONS.

In the September, 1905, number of *The American Journal of Obstetrics and the Diseases of Women and Children,* Dr. Barton Cook Hirst, Philadelphia, in a paper. "The Mortality of operations, other than strumectomy, in cases of exophthalmic Goitre, with special reference to Gynecological Operations." No one had sufficient experience with this complication to give an opinion. To learn the collective experience of American surgeons Dr. Hirst addressed 366 communications to members of National Societies of Surgery and Gynecology. He was able to collect 71 cases upon which various operations had been made, from extraction of teeth to the gravest abdominal section, and amputation of limbs. It appears from the statistics that the existence of Exophthalmic Goitre, adds more than 15% to the mortality of any operation performed on the patient.

Consequently an operation of election, such as suspension of the uterus or plastic operations in the vagina should be considered unjustifiable on such patients unless a preparatory or curative treatment is discovered that will lessen the danger. Local anaesthesia may be demonstrated to be preferable to general anaesthesia, but while the subjects of exophthalmic goitre cannot be said to take an anaesthetic well the alarming symtoms of acute thyroidism do not, as a rule, appear during or directly after the anaesthetic, but usually at the expiration of a day or two when the effects of the anaesthetic have worn off.

Possibly the best results may be obtained with Barker's method of employing adrenalin chloride and blucain.

Dr. Hirst reports two cases with exophthalmic goitre where he was forced to make operations, both cases recovered. In one case there was profound collapse two days after operation, when the patient's pulse rose to 180. Some improvement was shown after hypodermoclysis and heart stimulant. A complete and rapid recovery was apparently secured in the next three or four days by the administration of suprarenal extract in three grain doses every four hours. He thinks intravenous injections of adrenalin chloride would be more efficacious, and will be his choice in the presence of urgent symptoms in future.

JOURNAL AND BOOK REVIEWS.

We have received a copy of the transactions of the Hawaiian Territory Medical Society. It is a neat volume, and contains many thoroughly readable articles; and reflects great credit upon the Society that publishes it.

One of the spiciest little Journals that comes to the Secretary is the *American Medical Journalist.* It contains many very readable articles, and its last issue seems to be chiefly directed against the various transactions of the American Medical Association, especially against the Journal. We rather think that there is a great deal of truth in what it has to say; and advise all who wish to know both sides of the question to read it. It is published by D. O'Gorman, of New York.

There has come to our office the *Washington Medical Annals,* Volume IV, No. 3. It is issued bi-monthly, and is a journal of the Medical Society of the District of Columbia. There are some excellent articles in it, and should be of considerable value to the District.

We beg to acknowledge the receipt of number II of the *Ohio State Medical Journal,* and we are glad to welcome Ohio into the list of the State Associations publishing journals.

The frontispiece is well gotten up and contains a map of the State, divided into counties and districts. A very excellent idea; but not one that we would wish to continue for any length of time. We have no doubt that the map of Ohio is an attractive proposition; but not one we would wish to stare us in the face month after month, and year after year. We suppose that Ohio will change this later on for a more atractive cover page. The journal is a much larger one than ours, and is more on the magazine order. We wish Ohio well, and think that such a large State can well support a good journal.

The last number of the *American Journal of Urology* has just come to the office of the Secretary, and it is an exceedingly high grade Journal. It contains many excellent articles, and is a Journal that should be on the desk of every surgeon, and is *par excellence* the leading Journal in that line.

To those who are not thoroughly familiar with the mosquito theory in relation to yellow fever, and the history of the stegomyia fasciata, we would respectfully refer them to Volume XIII of the *Yellow Fever Institute,* published as far back as March, 1903, which gives the report of working party No. 1 at Vera Cruz. It is published by the Government, and can be obtained by any one desiring it, from the Surgeon General, unless the issue has been exhausted.

There is a report to the effect that Doctors P. E. and John J. Archinard, of New Orleans, think that they have detected the yellow fever germ. This germ, which has been puzzling Bacteriologists for years and so far has eluded the best of them, would confer a great blessing upon mankind if it would allow itself to be discovered. Especially would this be the case, if it would allow itself to be discovered in New Orleans at present.

DIRECTORY OF COUNTY SOCIETIES.

Abbeville, Sec., Dr. C. C. Gambrell, Abbeville, S. C.

Aiken, Sec. Dr. W. C. R. Turnbull, Aiken, S. C.

Anderson, Sec., Dr. J. B. Townsend, Anderson, S. C.

Bamberg, Sec., Dr. J. J. Cleckley, Bamberg, S. C.

Barnwell, Sec., Dr. L. F. Bonner, Blackville, S. C.

Beaufort, Sec., Dr. M. G. Elliott, Beaufort, S. C.

Berkeley,—Not organized.

Charleston, Sec., Dr. J. C. Mitchell, Charleston, S. C.

Cherokee, Sec., Dr. B. L. Allen, Gaffney, S. C.

Chester, Sec., Dr. W. B. Cox, Chester, S. C.

Chesterfield,—Not organized.

Clarendon, Sec., Dr. L. C. Stukes, Summerton, S. C.

Colleton, Sec., Dr. Chas Es Dorn, Walterboro, S. C.

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Dorchester, Sec., Dr. J. B. Johnston, St. George's, S. C.

Edgefield, Sec., Dr. J. G. Edwards, Meeting St., S. C.

Fairfield, Sec., Dr. R. B. Hannahan, Winnsboro, S. C.

Florence, Sec., Dr. F. H. McLeod, Florence, S. C.

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Greenville, Sec., Dr. J. R. Ware, Greenville, S. C.

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Marion, Sec., Dr. H. A. Edwards, Latta, S. C.

Lee, Sec., Dr. L. H. Jennings, Bishopville, S. C.

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Newberry, Sec., Dr. J. G. McMaster, Newberry, S. C.

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Oconee, Sec., Dr. D. L. Smith, Newry, S. C.

Pickens, Sec., Dr. H. E. Russell, Easley, S. C.

Richland, Sec., Dr. Mary R. Baker, Columbia, S. C. (Columbia County Medical Co.)

Saluda, Sec., Dr. J. D. Waters, Coleman, S. C.

Spartanburg, Sec., Dr. O. W. Leonard, Spartanburg, S. C.

Sumter, Sec., Dr. Walter Cheyne, Sumter, S. C.

Union, Sec., Dr. Theo. Maddox, Union, S. C.

Wiliamsburg,—Not organized.

York, Sec., Dr. J. R. Miller, Rock Hill, S. C.

COUNTY SOCIETIES WITH MEMBERS.

[The Secretary begs to publish the following list of Counties with members.]

The following Counties, with members, have thus far affiliated themselves with the Association under the new constitution. Delinquent Counties or those contemplating affiliation with the State body are requested to do so not later than November 1st, as the list will then be closed for the fiscal year,

County Secretaries are requested to report any errors or omissions promptly, so that corrections can be made for the next issue.

T. P. WHALEY, M. D., Secretary,
Charleston. S. C.

ABBEVILLE.

(ABBEVILLE COUNTY MEDICAL SOCIETY.)

G. A. Neuffer	Abbeville.
F. E. Harrison	Abbeville.
L. T. Hill	Abbeville.
C. C. Gambrell	Abbeville.
J. W. Wideman	Due West.
J. R. Bell	Due West.
J. M. Carlton	Mt. Carmel.
P. R. Black	Mt. Carmel.
T. O. Kirkpatrick	Lowndesville.
J. D. Wilson	Lowndesville.
J. B. Britt	Troy.
J. A. Anderson	Autreville.
D. S. Knox	Autreville.
J. W. Keller	Abbeville.

BARNWELL.

(BARNWELL COUNTY MEDICAL SOCIETY.)

D. K. Briggs	Blackville.
—— Hickson	Kline.
R. C. Kirkland	Barnwell.
E. L. Patterson	Barnwell.
J. A. McCreary	Williston.
L. F. Bonner	Blackville.
W. C. Smith	Williston.

CHARLESTON.

(MEDICAL SOCIETY OF SOUTH CAROLINA.)

Aimar, C. P.	Charleston.
Alston, R.	Charleston.
Baker, A. E.	Charleston.
Barbot, L. D.	Charleston.
Brodie, R. L.	Charleston.
Buist, J. S.	Charleston.
Buist, A. J.	Charleston.
Cathcart, R. S.	Charleston.
Cornell, W. P.	Charleston.
DeSaussure, H. W.	Charleston.
Forrest, Jno.	Charleston.
Frampton, J. W.	Mt. Pleasant.
Galvin. J. P.	Charleston.
Green, J. M.	Charleston.
Huger, W. H.	Charleston.
Hunter, B. W.	Charleston.
Jackson, H. P.	Charleston.
Johnson, W. H.	Charleston.
Kirk, R. D.	Charleston.
Kollock, C. W.	Charleston.
Maybank, Jos.	Charleston.
Mood, G. McF.	Charleston.
Mazyck, Wm.	Charleston.
Memminger, A.	Charleston.
Mullally, L.	Charleston.
Parker, E. F.	Charleston.
Parker, F. L.	Charleston.
Porcher, W. P.	Charleston.
Rees, C. M.	Charleston.
Rutledge, Edw.	Charleston.
Scharlock, T. M.	Charleston.
Schroeder, C. H.	Charleston.
Simons, M.	Charleston.
Simons, T. G.	Charleston.
Whaley, T. P.	Charleston.
Wilson, G. F.	Charleston.
Wilson, J. LaR.	Charleston.
Wilson, Robt.	Charleston.
Taft, A. R.	Charleston.
Burn, W.	Charleston.
Taylor, J. S.	Charleston.
Johnson, F. B.	Charleston.
Mitchell, J. C.	Charleston.

CHEROKEE.

(CHEROKEE COUNTY MEDICAL SOCIETY.)

M. W. Smith	Gaffney.
C. M. Littlejohn	Gaffney.
B. B. Studley	Gaffney.
J. N. Nesbit	Gaffney.
B. L. Allen	Gaffney.
W. L. Settlemeyer	Gaffney.
J. T. Darwin	Gaffney.
R. F. McKown	Cherokee Falls.
C. A. Jeffries	Gaffney.
S. H. Griffith	Gaffney.
S. B. Crawley	Gaffney.
B. R. Brown	Gaffney.
W. Anderson	Blacksburg.

CHESTER.

(CHESTER COUNTY MEDICAL SOCIETY.)

S. W. Pryor	Chester.
H. E. McConnell	Chester.
J. G. Johnson	Chester.
S. G. Miller	Chester.
J. P. Young	Richburg.
T. B. Kell	Catawba.
W. DeK. Wylie	Richburg.
R. L. Douglas	Rodman.
A. M. Wylie	Chester.
J. M. Brice	Chester.
A. F. Anderson	Laceysville (Hon.)
G. W. Jordan	Rodman. (Hon.)
W. B. Cox	Chester.
F. M. Durham	Blackstock.

COLLETON.

(COLLETON COUNTY MEDICAL SOCIETY.)

C. S. EsDorn	Walterboro.
W. B. Ackerman	Walterboro.
Riddick Ackerman	Walterboro.
Benjamin Willis	Walterboro.
J. T. Taylor	Adams Run.

DORCHESTER.

(DORCHESTER COUNTY MEDICAL ASSOCIATION.)

J. T. Carter	Branchville.
W. M. Carn	St. George.
A. H. Hayden	Summerville.
J. S. Wimberly	Branchville.
A. R. Johnston	Reevesville.
J. P. Mellard	St. George.
J. P. Johnston	St. George.
P. M. Judy	St. George.
P. L. Horn	St. George.
H. B. Lee	Summerville.

GREENWOOD.

(GREENWOOD COUNTY MEDICAL SOCIETY.)

W. T. Jones	Jones.
S. L. Swygert	Greenwood.
John Lyon	Ninety-Six.
J. E. Hughey	Greenwood.
W. P. Barratt	Greenwood.
E. O. Jenkins	Troy.
E. O. Devlin	Verdery.
J. C. Harper	Greenwood.
G. P. Neel	Greenwood.
R. B. Epting	Greenwood.

HAMPTON.

(HAMPTON COUNTY MEDICAL SOCIETY.)

Southward Smith	Brighton.
J. L. Folk	Brunson.
C. A. Rush	Hampton.
M. B. Monsen	Luray.
N. C. Johnson	
J. W. Colson	Varnville.
C. P. Walter	Crocketsville.
C. R. Peeples	
C. P. Vincent	Varnville.

KERSHAW.

(KERSHAW COUNTY MEDICAL ASSOCIATION.)

W. J. Burdell	Lugoff.
A. W. Burnet	Camden.
S. C. Zemp	Camden.
A. A. Moore	Camden.
J. W. Corbett	Camden.
W. J. Dunn	Camden.
S. F. Brasington	Camden.
W. R. Clyburne	Camden.
J. T. Hay	Boykins.

LEE.

(LEE COUNTY MEDICAL SOCIETY.)

R. Y. McLeod	Bishopville.
J. E. McLure	Bishopville.
J. B. Manning	Bishopville.
A. C. Baskins	Bishopville.
B. McLaughlin	Bishopville.
L. H. Jennings	Bishopville.
E. F. Darby	Magnolia.
J. W. Tarrant	Magnolia.
B. L. Harris	St. Charles.
A. H. Brown	Rural.
J. B. Bullock	Lucknow.
J. D. Foxworth	Smithville.

LEXINGTON.

(LEXINGTON COUNTY MEDICAL SOCIETY.)

W. Price Timmerman	Batesburg.
J. J. Wingard	Lexington.
J. P. Drafts	Gilbert.
F. R. Geiger	New Brookland.
C. W. Barron	New Brookland.
Theo. A. Quattlebaum	Batesburg.
D M. Crosson	Leesville.

MARION.

(MARION COUNTY MEDICAL SOCIETY.)

A. D. Lewis	Nichols.
Z. G. Smith	Marion.
F. A. Smith	Mullins.
A. McIntyre	Marion.
J. G. Rogers	Poges Mill.
F. L. Carpenter	Latta.
C. Henslee	Dillon.
B. M. Badger	Dillon.
H. A. Edwards	Latta.
E. M. Dibble	Marion.
A. M. Brailsford	Mullins.
E. B. Uttey	
C. T. Ford	Mullins.

MARLBORO.

(MARLBORO COUNTY MEDICAL SOCIETY.)

J. F. Kinney	Bennettsville.
W. M. Reedy	Clio.
J. H. Reese	Tatum.
J. L. Napier	Blenheim.
C. D. Napier	Blenheim.
C. R. May	Blenheim.
C. S. Evans	Clio.
J. A. Hamer	McColl.
J. C. Moore	Bennettsville.
J. L. Jordan	Bennettsville.
A. S. Townsend	Bennettsville.
J. A. Faison	Bennettsville.
W. J. Crosland	Bennettsville.
J. A. Woodley	
D. Hamer	McColl.

OCONEE.

(OCONEE COUNTY MEDICAL SOCIETY.)

J. H. Stribling	Seneca.
E. A. Hines	Seneca.
W. R. Doyle	Seneca.
E. C. Doyle	Seneca.
J. W. Bell	Walhalla.
J. H. Moore	Walhalla.
B. F. Sloan	Walhalla.
C. M. Walker	Westminster.
A. M. Redfern	Clemson.
D. L. Smith	Newry.
J. M. Wickliffe	West Union.

PICKENS.

(PICKENS COUNTY MEDICAL SOCIETY.)

R. J. Gilliland	Easley.
L. G. Clayton	Central.
H. E. Russell	Easley
J. L. Bolt	Pickens.
W. A. Tripp	Easley.
W. A. Sheldon	Liberty.
J. E. Allgood	Liberty.
C. N. Wyatt	Easley.
R. Kirksey	Pickens.
E. B. Webb	Pickens.
L. F. Robinson	Dacusville.
W. M. Long	Liberty.
J. O. Rosamond	Easley.

RICHLAND.

(COLUMBIA MEDICAL SOCIETY.)

S. B. Fishburne	Columbia.
I. P. McIntosh	Columbia.
William Weston	Columbia.
E. I. Wannamaker	Columbia.
C. F. Williams	Columbia.
S. M. Deal	Columbia.
P. V. Mikell	Columbia.

Henry Horlbeck.....Columbia.
W. M. Lester.....Columbia.
E. M. Whaley.....Columbia.
S. E. Harmon.....Columbia.
L. K. Philpot.....Columbia.
R. L. Moore.....Columbia.
L. A. Griffith.....Columbia.
J. H. Burkhalter.....Columbia.
L. B. Owens.....Columbia.
Mary R. Baker.....Columbia.

SALUDA.

(SALUDA COUNTY MEDICAL SOCIETY.)

J. C. W. Kennerly.....Mt. Willing.
D. B. Frontes.....Ridge Spring.
J. D. Waters.....Coleman.
L. J. Smith.....Ridge Spring.
J. J. Kirksey.....Saluda.
S. M. Pitts.....Big Creek.
F. G. Asbill.....Ridge Spring.
W. B. Smith.....Wards.
G. L. Trotter.....Fox.

SPARTANBURG.

(SPARTANBURG COUNTY MEDICAL SOCIETY.)

John O. Vernon, President.....Welford.
O. W. Leonard, Secretary.....Spartanburg.
J. L. Jefferies, Treasurer.....Spartanburg.
F. L. Potts.....Spartanburg.
J. H. Allen. Vice-President.....Spartanburg.
R. M. Dorsey.....Spartanburg.
L. J. Blake.....Spartanburg.
Geo. R. Dean.....Spartanburg.
A. D. Cudd.....Spartanburg.
A. R. Fike.....Spartanburg.
G. A. Bunch.....Spartanburg.
J. R. Brown.....Spartanburg.
G. DeFoix Wilson.....Spartanburg.
H. R. Black.....Spartanburg.
J. F. Williams.....Roebuck.
W. G. Sexton.....Spartanburg.
W. J. Chapman.....Inman.
[R. F. D. No. 2.
J. J. Lindsay.....Spartanburg.
Lee J. Wall.....Spartanburg,
W. L. Kirkpatrick.....Pacolet.
H. B. Tate.....Pacolet.
J. R. Gibson.....Inman,
W. P. Coan.....Spartanburg.
[R. F. D. No. 5.
W. A. Smith.....Glendale.
W. H. Kelly.....Walnut Grove
D. R. Norman.....Fair Forest
R. G. Hamilton.....Converse.
J. W. Allen.....Enoree.

SUMTER.

(SUMTER COUNTY MEDICAL SOCIETY.)

J. C. Spann.....Sumter.
R. B. Furman.....
P. M. Salley.....Pinewood.
M. L. Parler.....Wedgefield.
Archie China.....Sumter.
F. M. Dwight.....Wedgefield.
C. P. Osteen.....Sumter.
R. M. Stuckey.....Sumter.
S. C. Baker.....Sumter.
J. A. Mood.....Sumter.
Walter Cheyne.....Sumter.

UNION.

(UNION COUNTY MEDICAL SOCIETY.)

J. M. Lawson.....Union.
C. Torrence.....Union.
M. W. Culp.....Union.
W. G. Fike.....Union.
C. W. Anstell.....Union.
R. R. Berry.....Buffalo.
S. G. Sarratt.....Union.
J. H. Hamilton.....Union.
J. G. Going.....Union.
W. O. Southard.....Jonesville.
M. W. Chambers.....Jonesville.
J. T. Jeter.....Santuc.
Theo. Maddox.....Union.
H. T. Hames.....Jonesville.
D. H. Montgomery.....Union.

YORK.

(YORK COUNTY MEDICAL SOCIETY.)

I. A. Bigger, President.....Clover,
[R. F. D. No. 2
T. A. Crawford, Vice-Pres.....Rock Hill.
J. R. Miller, Sec.....Rock Hill.
J. D. McDowell, Treas.....Yorkville.
J. E. Massey, Sr.....Rock Hill.
J. E. Massey, Jr.....Rock Hill.
W. M. Love.....McConnellsville.
M. J. Walker.....Yorkville.
W. G. Stevens.....Rock Hill.
T. S. R. Ward.....Hickory Grove.
J. H. Saye.....Sharon.
A. S. Lynn.....Rock Hill.
W. W. Fennell.....Rock Hill.
L. L. Campbell.....Rock Hill.
T. B. Hough.....Newport.
B. N. Miller.....Smyrna.
T. R. Carothers.....Rock Hill.
R. A. Bratton.....Yorkville.
W. G. White.....Yorkville.